Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 20, 2021	2020_773155_0021	012712-20, 017461-20, 019250-20, 019501-20	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Creedan Valley Care Community
143 Mary Street Creemore ON L0M 1G0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SHARON PERRY (155), KIM BYBERG (729)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 14-18, 2020.

The following intakes were completed during this inspection:
Log #019501-20 related to alleged abuse;
Log #019250-20 related to a fall;
Log #017461-20 follow up to CO #001 from inspection 2020_836766_0009 regarding residents' rights; and
Log # 012712-20 follow up to CO #005 from inspection 2020_781729_0005 regarding medication administration.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Directors of Care, Programs Manager, Dietary and Support Services Manager, Director of Compliance and Clinical Services, Medical Director, Registered Nurse, Registered Practical Nurses, Personal Support Workers, and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #005	2020_781729_0005	729
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2020_836766_0009	155

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order (CO) #005 from inspection #2020_781729_0005 served on October 23, 2020, with a compliance due date of November 20, 2020.

The home was to ensure that any new or existing prescribed medication was transcribed, processed and checked in accordance with the home's policies and this was not done.

Four residents had medications prescribed by the physician. The medications were administered to the residents before the physician orders were checked to ensure there were no discrepancies in the prescription or in the processing of the order. The second check of the medications was not completed until seventy-two hours after the physician orders were received.

The home follows the policies of their contracted pharmacy, Medical Pharmacies. The policy titled "Ordering and Receiving Medication", stated that the nurse was to complete the first check after the transmission of the order to the pharmacy was verified, the electronic medical administration record (eMAR) was checked with the original physician order, changed or discontinued medications were flagged or removed and that informed consent was obtained. The second nurse check was to be completed when the medication was received.

The ADOC stated that the first and second checks of the medications should be completed within 24 hours of the medication being prescribed and before the medication was administered to the resident.

The home did not ensure that all medications were checked and processed prior to administering medications to the residents. This poses significant risk to the residents of a medication incident that has the potential to cause harm or injury.

Sources: Ordering and Receiving Medication" policy, interview with RPN and ADOC, record review of resident's eMARs and Physician orders. [s. 101. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to their investigation of alleged abuse.

A critical incident report (CI) was submitted to the Ministry of Long Term Care (MLTC) with an allegation of staff to resident abuse.

It was reported by two staff members to a registered staff that a staff member made verbal comments to a resident that upset them.

The home completed an investigation into the allegations and found that the allegation of abuse was unfounded. However, the home did not collect written statements, interview the staff reporting the allegation, and did not ask for written statements from the staff member to which the allegation of abuse was directed.

The home's policy titled "Prevention of Abuse and Neglect of a Resident", stated that anyone aware of, or involved in the situation write, sign, and date a statement accurately describing the event. The Executive Director or designate would interview the persons who may have any knowledge of the situation.

By the home not receiving statements or interviewing all persons involved in the allegation of abuse, there was risk that information may not have been taken into account and further necessary follow up may not have been completed to ensure compliance of zero tolerance of abuse and neglect of residents. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen that the resident was assessed.

A resident was found on the floor in their room. The resident complained of pain. There was no assessment of the resident's location of pain, where in the room the resident fell or how the resident was positioned on the floor, or if the falls interventions were in place at the time of the fall.

The resident continued to experience pain and an x-ray done at a later date revealed that they had an injury. Had a comprehensive post fall assessment been completed, it may have identified the source of the pain and lead to a more timely diagnoses.

Sources: CIS report; Falls Prevention and Management policy (dated February 2020); Post Fall Incident Form/Risk Management Form for the resident; resident's progress notes; and interviews with an RN and other staff. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-falls assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 25th day of January, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHARON PERRY (155), KIM BYBERG (729)
Inspection No. / No de l'inspection :	2020_773155_0021
Log No. / No de registre :	012712-20, 017461-20, 019250-20, 019501-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 20, 2021
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Creedan Valley Care Community 143 Mary Street, Creemore, ON, L0M-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Order / Ordre :

The licensee must be compliant with s. 101.(3) of the LTCHA.

Specifically, the licensee must:
a) Ensure that any new or existing prescribed medication orders for resident #003, #004, #005, #006 are transcribed, processed and checked in accordance with the home's policies.

b) Provide all registered staff with re- education on Medical Pharmacies policy titled "Ordering and Receiving Medication" policy #4-2-1. Records of the re-education provided shall be maintained, documented and kept in the home.

c) Implement an auditing process to ensure that physician orders are transcribed, processed and checked in accordance with the home's policies. This auditing process must be documented and include the names of the staff conducting the audit, the date the audit was done, the results of the audit and what actions were taken with regards to the audit. The audit is to be completed at least weekly until the licensee is satisfied with the audit results.

Grounds / Motifs :

1. The licensee has failed to comply with Compliance Order (CO) #005 from inspection #2020_781729_0005 served on October 23, 2020, with a compliance due date of November 20, 2020.

The home was to ensure that any new or existing prescribed medication was transcribed, processed and checked in accordance with the home's policies and

this was not done.

Four residents had medications prescribed by the physician. The medications were administered to the residents before the physician orders were checked to ensure there were no discrepancies in the prescription or in the processing of the order. The second check of the medications was not completed until seventy-two hours after the physician orders were received.

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The ADOC stated that the first and second checks of the medications should be completed within 24 hours of the medication being prescribed and before the medication was administered to the resident.

The home did not ensure that all medications were checked and processed prior to administering medications to the residents. This poses significant risk to the residents of a medication incident that has the potential to cause harm or injury.

Sources: Ordering and Receiving Medication" policy, interview with RPN and ADOC, record review of resident's eMARs and Physician orders. [s. 101. (3)]
An order was made by taking the following factors into account:

Severity: There was actual risk to the four residents when medication orders were not checked by a second registered staff. The second check did not take place until 72 hours after the order was processed.

Scope: Out of the four residents reviewed, four residents received their medications prior to the second check by registered staff, demonstrating wide spread non-compliance.

Compliance History: Two previous voluntary plans of correction (VPC) for the same section of the legislation, as well as 9 written notifications (WN), 33 VPCs and 43 compliance orders (CO) for different sections of the legislation were issued to the home in the last 36 months.

(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 11, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHARON PERRY

Service Area Office /
Bureau régional de services : Central West Service Area Office