Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 21, 2021	2020_773155_0022	025496-20	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 22, 23, 24, 30, 2020 and January 4, 5, 6, 7, 2021.

The following intake was completed in this complaint inspection:
Log #025496-20 related to alleged abuse/neglect and residents not receiving their baths.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Directors of Care, Resident Relations Coordinator, Director of Compliance and Clinical Services, Medical Director, Registered Nurse (RN), Registered Practical Nurses (RPN), Physiotherapy Assistant, 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:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's substitute decision maker was informed of their transfer to hospital.

A RPN transferred a resident to hospital. The substitute decision maker was not informed that the resident had been transferred to hospital.

The RPN shared that they did not call the resident's substitute decision maker as the resident was capable of making their own decisions and it was at the end of their shift.

Sources: the resident's progress notes; complaint home received from family; and interviews with Resident Relations Coordinator and other staff. [s. 3. (1) 16.]

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 every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately, to be implemented voluntarily.

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 progress note and risk management report were completed regarding an incident of alleged staff to resident abuse.

It was reported to the Director of Care that a resident reported that a personal support worker was rough and yelled at 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 from the staff member accused of the abuse nor were interviews done with other residents who may have had knowledge of the situation.

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 had any knowledge of the situation.

By the home not receiving statements or interviewing all persons who may have had knowledge of the alleged abuse, there was risk that information may not have been taken into account and necessary follow up may not have been completed to ensure compliance with 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director of Care immediately reported an allegation of alleged staff to resident abuse to the Director.

On an identified date, a RPN heard yelling from a resident. The resident reported to the RPN that a PSW was rough with them. The resident was crying. The RPN reported this immediately to the Director of Care.

The Director of Care did not immediately report this suspicion of alleged abuse and the information upon which it was based to the Director. As a result, the Director was unaware of the alleged abuse between the PSW and the resident and the incident was not recorded in the Critical Incident System.

Sources: The home's investigative notes; progress notes and risk management report for the resident and interviews with the DOC and other staff. [s. 24. (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 any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that Registered Practical Nurse #116 kept their medication cart secured and locked.

On an identified date, the Lilly Way medication cart was left unattended and unlocked by the documentation room near A wing nursing station across from the lounge area where residents were seated. A resident was observed near the medication cart and was self propelling their wheelchair and reaching for things.

The RPN acknowledged that the medication cart should not have been left unlocked and unattended. As there were residents in the area there was a risk that they could have obtained medications from the unlocked cart.

Sources: observations of the medication cart and interview of RPN . [s. 129. (1) (a) (ii)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The following is further evidence to support the compliance order #005 issued on 0ctober 14, 2020 during inspection 2020_781729_0005 (A2) to be complied by November 20, 2020.

1. Resident #002 was administered a medication at 1700 hours for a period of six days when the prescriber had prescribed it to be administered at bedtime.

2. Resident #009 was administered a wrong dose of a medication for a period of twenty days.

Sources: Resident #002 and #009's physician orders; resident #002 and #009's progress notes and medication administration record (MAR); and interviews with RPN, DOC and other staff. [s. 131. (2)]

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.