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

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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
May 4, 2021	2021_781729_0012	001519-21, 001902-21, 002517-21, 002518-21, 003585-21, 003926-21, 004601-21	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

KIM BYBERG (729), SHARON PERRY (155)

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): March 24 - 26, 29 - 31, April 1, 6 - 9, 12 - 16, 19, 2021.

The following intakes were completed within the critical incident (CI) inspection:

Log #001519-21, follow-up to compliance order #001 from inspection #2020_773155_0021, related to medication management;

Log #001902-21,
Log #002517-21,
Log #002518-21,
Log #003585-21,
Log #003926-21,
and Log #004601-21, all related to allegations of resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), RAI - Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Wound Specialist, Foot Care Nurse, Practical Nursing Student (PNS), PrimaCare Director of Compliance and Clinical Operations (DOCCO).

During this inspection, inspector(s) toured the home, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, and observed the general maintenance, cleanliness, safety and condition of the home.

This inspection was completed concurrently with complaint inspection #2021_781729_0013.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
1 VPC(s)
0 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
LTCHA, 2007 S.O. 2007, c.8 s. 101. (3)	CO #001	2020_773155_0021	729

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 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 has failed to ensure that the medication cart was kept secure and locked.

Observations during the inspection showed the medication cart located at the nursing station was left unattended and unlocked. There were seven residents near the cart when observations were completed.

When the medication cart was left unattended and unlocked there was a risk that residents could have taken medications from the cart that were not prescribed for them.

Sources: Observation during inspection, Interview with RAI-Coordinator and RPN. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 and #001, were protected from neglect by staff, when staff failed to adequately assess the residents after they experienced a change in their medical condition.

The following is further evidence to support CO #001, issued in inspection #2021_836766_0005.

Section 5 of Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #008, was observed to have an injury of an unknown cause.

There was no neurological assessment, vitals signs, or first aid provided to the resident as a result of the injury. Staff reported that when a resident sustained an injury to their head they were to complete an assessment that included vital signs and a neurological assessment.

The resident was at risk of developing a neurological deficit due to staff not assessing the resident and providing them with first aid if required.

Sources: Record review of progress notes, Vital signs, head to toe assessment, Interview with staff members, and DOC. [s. 19. (1)]

2. The licensee has failed to ensure that resident #001, was protected from neglect by staff when staff failed to assess the resident, after a medical event.

PSW #110 discovered resident #001 to be unresponsive.

When the resident regained consciousness, registered staff did not conduct an assessment of them. Further, the incident was not reported to oncoming staff during shift change, the physician was not notified about the incident and the incident was not documented until 11 days later.

Sources: resident #001's progress notes, vital signs, lab reports, Prevention of Abuse & Neglect of a Resident Policy (dated April 2019); interviews with PN Student #113 and other staff. [s. 19. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a critical incident report, included the names of the staff members involved in an incident of alleged abuse of resident #008.

A Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) related to an allegation of resident abuse that resulted in an injury to resident #008.

The CI did not contain the names of the staff members that were involved in the alleged incident.

There was no risk of harm to resident #008, due to the home not reporting the staff members names to the Director.

Sources: Record review of the CI, Interview with the DOC and PrimaCare DOCCO. [s. 104. (1) 2.]

Issued on this 11th day of May, 2021

[redacted]

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

Original report signed by the inspector.