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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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
Jul 8, 2021	2021_773155_0010	004645-21, 004646-21, 004647-21, 004687-21, 005790-21, 005917-21, 006216-21, 006240-21, 006394-21, 006940-21, 006942-21	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), KATY HARRISON (766), KIM BYBERG (729), NUZHAT UDDIN (532)

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): May 12-14, 17-21, 25-28, May 31, June1-4, June 7 and 9, 2021.

The following intakes were completed in this complaint inspection:
Log 006942-21, 006940-21, and 005917-21 complaints related to alleged neglect;
Log 006240-21 complaint related to diet options and fluid records;
Log 005790-21 complaint related to alleged discouraging reporting and retaliation;
Log 006394-21 / Critical Incident (CI) related to alleged neglect;
Log 006216-21 / CI related to alleged improper care and treatment;
Log 004687-21 follow up to compliance order (CO) #001 from inspection 2021_836766_0005 regarding neglect;
Log 004647-21 follow up to CO #001 from inspection 2021_836766_0004 regarding care provided as per plan of care;
Log 004646-21 follow up to CO #003 from inspection 2021_836766_0004 regarding reporting alleged abuse/neglect to the director;
and Log 004645-21 follow up to CO #002 from inspection 2021_836766_0004 regarding immediately investigating allegations of abuse/neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Directors of Care, Clinical Consultant-Director of Compliance, Registered Dietitian, Support Services Supervisor, Scheduling Coordinator, Environmental Services Manager, Resident Experience Partner, Resident Relations Behaviour Support Lead, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aides, Maintenance Aide, and residents.

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

Inspectors #694420 and #705751 were also present during this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **4 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. 19. (1)	CO #001	2021_836766_0005	155
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2021_836766_0004	532
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2021_836766_0004	532

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

The care plan for a resident directed staff to turn and reposition the resident every two hours when in bed.

Record review supported that on an identified date and time, the resident was turned and repositioned, however they were not turned and repositioned again until five hours later.

The PSW stated that they were aware that the resident needed to be turned and repositioned every two hours.

Failure to follow the plan of care for the resident posed a potential risk to the resident for developing altered skin integrity.

Sources: Critical Incident System report, plan of care for the resident, Point of Care (POC) documentation, investigation notes and interview with two PSWs and the DOC. [s. 6. (7)]

2. The licensee failed to ensure that a resident was provided care by two staff as per their plan of care.

The resident's current care plan stated the resident was to have two staff present for cares.

On two days during the inspection, a PSW was observed alone in the resident’s room providing care.

Sources: Resident's plan of care, observations and interviews with two PSWs and DOC. [s. 6. (7)]

3. The licensee failed to ensure that when a resident's plan of care related to responsive behaviours was being revised due to it being ineffective, that different approaches were considered in the revision of their plan of care.

The resident's care plan indicated that the resident had responsive behaviours. Interventions to respond to their behaviours were included in their care plan.

According to a number of staff interviewed during the inspection, the interventions were not always effective and therefore the resident did not receive specific care.

An Associate Director of Care was aware of the responsive behaviours and gave direction to staff. When staff tried to implement the suggested strategy it was ineffective.

Failure to implement different approaches resulted in the resident not receiving specific cares.

Sources: Plan of care for the resident, Point of Care (POC) documentation, electronic treatment administration record (e-TAR) and interviews with PSWs and RPN. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 is reassessed and their plan of care reviewed and revised, because care set out in their plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a RPN documented their assessment of a resident, interventions taken and the resident's response to the interventions.

After a resident had eaten, a PSW reported to a RPN that the resident needed to be assessed due to them having difficulty breathing. The staff shared that the RPN went to see resident. Later that same day, another PSW also reported that they needed help repositioning the resident due to them being slumped over in their chair, which was not normal behaviour for the resident, and the RPN responded.

There was no documentation about the resident, including any assessments, interventions or response to interventions for the resident by the RPN.

The resident was assessed later by an RN and was sent and admitted to the hospital.

A lack of documentation by the RPN, may have resulted in a delay of treatment for the

resident.

Sources: the resident's progress notes, hospital transfer summary and interviews with two PSWs and two RPNs. [s. 30. (2)]

2. The licensee failed to ensure that three resident's fluid intake was documented correctly.

A) Two residents were observed during lunch and supper to drink from a blue plastic mug. One resident drank 870 millilitres (mls) of fluid at these meals and not the 1000 mls that was documented. The other resident drank 900 mls of fluid at these meals and not the 1000 mls that was documented.

Staff were instructed that the blue plastic mug held 2 units (250 mls) of fluid, when in fact the mug held only 200 mls. As a result, the resident's fluid intake documentation was inaccurate and indicated the residents drank more fluids than they actually consumed; placing the residents at potential risk for hydration issues.

Sources: Observations of residents at lunch and supper; resident Point Click Care fluid intake records, the homes approved cup size guide/picture, interviews with Support Services Supervisor and other staff.

B) The licensee failed to ensure that another resident's fluid intake was documented correctly.

The resident was observed during lunch and supper to drink from two plastic glasses each holding 2.4 units (300 mls) and not 375 mls as per the staff's understanding. As a result, the resident drank 1200 mls of fluid at these meals and not the 1250 mls documented.

Staff not knowing the units of fluid held by the plastic glass, put the resident at risk of hydration issues as their fluid intake records were not accurate.

Sources: Observations at lunch and supper; resident's care plan, Point Click Care fluid intake records and interviews with PSWs and other staff. [s. 30. (2)]

3. The licensee failed to ensure that a resident's care checklist was completed at the time the care was provided.

Review of the care checklist showed at times that there was no care documented on the checklist.

During this inspection, Inspectors #155 and #694420 observed the care checklist and the last documented care provided was at 0400 hours. After 1335 hours, a PSW documented the care that was provided at 0730 hours, 1230 hours and 1300 hours. They also documented the initials of the second staff who provided care at 0730 hours.

A completed care checklist would not have been available for the resident to provide reassurance to them that care was provided and by whom.

Sources: Resident care checklists; observations of care, interview with PSW and DOC. [s. 30. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the hydration program included the implementation of interventions to mitigate and the manage risks related to residents with low fluid intake.

The Hydration and Nutrition Monitoring policy stated that the nurse would review the electronic three Day Look Back Reports daily for undesirable intake trends and gaps over a 72-hour period. For residents drinking six servings or less of fluid for three consecutive days, the resident would be assessed for signs and symptoms of dehydration.

Staff had varying responses about the home's process for monitoring the fluid intake status of residents.

The Registered Dietitian shared that policies came from head office however, they were concerned about a resident's fluid intake status if the resident was consuming less than 1000 millilitres (8 units) in 24 hours for three consecutive days and not the 750 millilitres (6 units) in 24 hours for three consecutive days as written in the policy.

The Director of Care (DOC) shared that registered staff on the night shift would run the fluid look back report for seven days for all residents in the home. They would then review and record the number of days that the resident drank less than 8 units of fluid on the hydration monitoring tool, the specific room list and make a progress note. If the resident had consistent days where they drank less than 8 units this was to be noted in the progress notes. If registered staff wanted to know what days in the last seven days the resident drank less than 8 units, they could run the fluid look back report.

A RN shared the same as the DOC with the exception that they would not document the consistent days when the resident drank less than 8 units of fluid in the progress notes. They said they would document the number of days out of seven in red ink that the resident did not drink 8 units of fluid on the unit specific room list.

Another RN shared the same as the DOC, however stated that consistent days were not identified, it was just the number of days the resident drank less than 8 units in the past seven days that was recorded.

On two identified dates, a resident was recorded to have drank 7 units and 6 units of fluid respectively. A progress note stated that the resident had not met their fluid target two out of seven days that week. An RPN reviewed the progress note and stated that meant the resident drank less than 8 units two consecutive days.

On an identified date, a resident was marked as 2/7 for fluid intake on the unit specific room list. A RN said that meant that the resident drank less than 8 units on any two days in the last seven days. Review of their fluid intake record showed that the resident drank less than 8 units of fluid on two consecutive days.

On an identified date, a resident was noted to be marked 2/7 for fluid intake on the unit specific room list. An RPN said that meant that the resident drank less than 8 units on any two days of the last seven days. Review of the resident's fluid intake record showed that the resident drank less than 8 units of fluid on the previous two consecutive days.

As there was no consistent understanding of the fluid monitoring system for residents consuming less than 8 units of fluid on consecutive days, residents were placed at risk for becoming dehydrated.

Sources: Resident progress notes, point click care fluid look back reports, unit specific room lists, hydration monitoring tool, interviews with RD, DOC and other staff, Hydration

& Nutrition Monitoring Policy. [s. 68. (2) (c)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the home's infection control program when they failed to offer or perform hand hygiene for residents before meals.

The home's hand hygiene policy stated that staff were to wash resident's hands before and after eating.

A PSW was assisting a resident with the set up of their lunch tray and did not offer nor perform hand hygiene for the resident prior to the resident eating.

One day at lunch service, three residents were not offered nor was hand hygiene performed prior to the residents eating. On another day at lunch service, two residents were not offered nor was hand hygiene performed prior to them eating.

The DOC stated that staff were expected to perform hand hygiene for residents prior to and after eating.

Sources: Observations, interviews with PSW, DOC, record review of the Hand Hygiene policy. [s. 229. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Head Injury Routine policy and procedures included in the resident care program were complied with.

In accordance with O.Reg. 79/10, s.30. the licensee was required to have a written description of each of the interdisciplinary programs, including falls prevention and management, required under section 48 of this Regulation that included relevant procedures that provide for methods to reduce risk and monitor outcomes.

Specifically, the staff did not comply with the home's policy and procedure "Head Injury Routine", which was part of their falls prevention and management program.

The Head Injury Routine policy stated that a head injury routine would be initiated on any resident who sustained or was suspected of a head injury and to be completed as per the schedule outlined or as ordered by the physician.

On a specified date, a resident fell and a head injury routine was initiated at the time of the fall to monitor the resident for a potential head injury. The head injury routine assessment was to be completed at four specified times. The head injury routine form and progress notes did not indicate that an assessment was completed during those times.

The resident not being assessed for a head injury at the times indicated on the head injury form could have resulted in staff failing to identify if the resident had developed a neurological deficit.

Sources: interviews with PSW, Registered Staff, DOC, record review of the head injury recorded form, Head Injury Routine Policy. [s. 8. (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 the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that temperatures were measured in two resident bedrooms in different parts of the home, in one resident common area, and in the designated cooling areas (front dining room, back dining room, B lounge and library) at least once every morning, once every afternoon between 1200 hours and 1700 hours and once every evening or night shift.

A memorandum to Long-Term Care Home (LTCH) Stakeholders dated April 1, 2021, advised of the changes to Ontario Regulation 79/10 under the LTCHA, 2007 to help protect the safety and comfort of residents. Licensees were required to measure and document the air temperature at a minimum, in certain specified areas in the LTCH at specified intervals and conditions as outlined in the legislation effective May 15, 2021. This also included when the outdoor temperature exceeded 26 degrees Celsius (C).

On June 7, 2021, a review of the home's Air Temperature Log Form showed that temperature and humidity readings were being measured and recorded once a day in a random location of the home.

The Maintenance Aide shared that temperatures were being recorded once a day and taken in a common zone within the home.

On June 9, 2021, the Executive Director and Environmental Services Manager shared that they were not aware of the changes to the air temperature regulations until June 8, 2021. They stated that their corporate Heat Contingency Protocols and Air Temperature Log form for June 2021 also did not reflect the revised air temperature regulations. By not recording and documenting the temperatures of resident rooms, one resident common area and designated cooling areas, the home may not identify when there was a heat related concern, which could put residents at risk.

Sources: Heat Contingency Protocols, Air Temperature Log Form-Maintenance June 2021; interviews with Environmental Services Manager and other staff. [s. 21. (2) 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 the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home and the temperatures required to be measured shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #7: 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 on Trillium Way was kept secure and locked.

On May 13, 2021, from 1245 to 1251 hours the medication cart located at the nursing station on Trillium Way was left unattended and unlocked. There was one resident wandering and two residents sitting near the cart at that time.

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: Observations on May 13, 2021 and interview with 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.

Issued on this 16th day of July, 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), KATY HARRISON (766), KIM BYBERG (729), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2021_773155_0010
Log No. / No de registre :	004645-21, 004646-21, 004647-21, 004687-21, 005790-21, 005917-21, 006216-21, 006240-21, 006394-21, 006940-21, 006942-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 8, 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
	Sadie Friesner

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

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

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

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_836766_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6(7) of the LTCHA.

Specifically, the licensee must:

a) Ensure that residents are turned and repositioned according to their plan of care.

b) Ensure that resident #017 is provided care by two staff as per the plan of care.

Grounds / Motifs :

1. Compliance order #001 related to the LTCHA, S. 6(7) from inspection 2021_836766_0004 issued on March 12, 2021, with a compliance due date of March 31, 2021 is being re-issued as follows:

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

The care plan for a resident directed staff to turn and reposition the resident every two hours when in bed.

Record review supported that on an identified date and time, the resident was turned and repositioned, however they were not turned and repositioned again until five hours later.

The PSW stated that they were aware that the resident needed to be turned and repositioned every two hours.

Failure to follow the plan of care for the resident posed a potential risk to the resident for developing altered skin integrity.

Sources: Critical Incident System report, plan of care for the resident, Point of Care (POC) documentation, investigation notes and interview with two PSWs and the DOC (532)

2. The licensee failed to ensure that a resident was provided care by two staff as per their plan of care.

The resident's current care plan stated the resident was to have two staff present for cares.

On two days during the inspection, a PSW was observed alone in the resident's room providing care.

Sources: Resident's plan of care, observations and interviews with two PSWs and DOC.

An order was made by taking the following factors into account:

Severity: There was a potential risk of harm to two residents by care not being provided as per plan of care.

Scope: The scope of this non-compliance was isolated as the plan of care was not followed for two out of the six residents reviewed during this inspection.

Compliance History: The licensee continues to be in non-compliance with s. 6(7) of the LTCHA, resulting in a compliance order (CO) being re-issued. CO#001 was issued on March 12, 2021 (inspection #2021_836766_0004) with a compliance due date of March 31, 2021. This subsection was issued as a director referral (DR) on June 8, 2020, during inspection #2020_781729_0005 with a compliance due date of December 20, 2020. In the past 36 months, 48 other compliance orders have been issued. (155)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jul 23, 2021

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Order / Ordre :

The licensee must be compliant with s. 30.(2) of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure that when a resident has a significant change in health status, that any actions taken with respect to the resident including assessments, interventions and the resident's response to the interventions are documented.

b) Ensure the home's approved cups photo list accurately identifies the correct amount of fluid volume in each type of resident cup or mug.

c) Ensure that fluid intake for resident #001, #018 and #019 is recorded correctly.

d) Ensure that the care checklist is completed at the time that care is provided to resident #017.

Grounds / Motifs :

1. The licensee failed to ensure that a RPN documented their assessment of a resident, interventions taken and the resident's response to the interventions.

After a resident had eaten, a PSW reported to a RPN that the resident needed to be assessed due to them having difficulty breathing. The staff shared that the RPN went to see resident. Later that same day, another PSW also reported that they needed help repositioning the resident due to them being slumped over in their chair, which was not normal behaviour for the resident, and the RPN

responded.

There was no documentation about the resident, including any assessments, interventions or response to interventions for the resident by the RPN.

The resident was assessed later by an RN and was sent and admitted to the hospital.

A lack of documentation by the RPN, may have resulted in a delay of treatment for the resident.

Sources: the resident's progress notes, hospital transfer summary and interviews with two PSWs and two RPNs. [s. 30. (2)] (155)

2. The licensee failed to ensure that three resident's fluid intake was documented correctly.

A) Two residents were observed during lunch and supper to drink from a blue plastic mug. One resident drank 870 millilitres (mls) of fluid at these meals and not the 1000 mls that was documented. The other resident drank 900 mls of fluid at these meals and not the 1000 mls that was documented.

Staff were instructed that the blue plastic mug held 2 units (250 mls) of fluid, when in fact the mug held only 200 mls. As a result, the resident's fluid intake documentation was inaccurate and indicated the residents drank more fluids than they actually consumed; placing the residents at potential risk for hydration issues.

Sources: Observations of residents at lunch and supper; resident Point Click Care fluid intake records, the homes approved cup size guide/picture, interviews with Support Services Supervisor and other staff.

B) The licensee failed to ensure that another resident's fluid intake was documented correctly.

The resident was observed during lunch and supper to drink from two plastic glasses each holding 2.4 units (300 mls) and not 375 mls as per the staff's

understanding. As a result, the resident drank 1200 mls of fluid at these meals and not the 1250 mls documented.

Staff not knowing the units of fluid held by the plastic glass, put the resident at risk of hydration issues as their fluid intake records were not accurate.

Sources: Observations at lunch and supper; resident's care plan, Point Click Care fluid intake records and interviews with PSWs and other staff. (155)

3. The licensee failed to ensure that resident #017's care checklist was completed at the time the care was provided and initialled by the two staff members completing the care.

The licensee failed to ensure that a resident's care checklist was completed at the time the care was provided.

Review of the care checklist showed at times that there was no care documented on the checklist.

During this inspection, Inspectors #155 and #694420 observed the care checklist and the last documented care provided was at 0400 hours. After 1335 hours, a PSW documented the care that was provided at 0730 hours, 1230 hours and 1300 hours. They also documented the initials of the second staff who provided care at 0730 hours.

A completed care checklist would not have been available for the resident to provide reassurance to them that care was provided and by whom.

Sources: Resident care checklists; observations of care, interview with PSW and DOC.

An order was made by taking the following factors into account:

Severity: Lack of documentation of the assessment, interventions and resident's responses to interventions; improper documentation of fluids consumed by residents; and not documenting on the care checklist for a resident at the time of care posed minimal harm.

Scope: The scope of this non-compliance was widespread as one out of three residents did not have an assessment documented when there was a significant change in status; three out of three residents did not have their fluid intake documented correctly; and one resident did not have their care checklist completed at the time care was provided.

Compliance History: Three written notifications (WNs) and one voluntary plan of correction (VPC) were issued to the home related to the same section of the legislation in the past 36 months. (155)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 23, 2021

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with s. 68.(2) of O. Reg. 79/10.

Specifically the licensee must:

a) Involve the registered dietitian who is a member of the staff of the home in the review of the home's Hydration and Nutrition Monitoring policy.

b) Review the Dietitians of Canada most current Best Practices for Nutrition, Food Service, and Dining in LTC Homes. Ensure the home's Hydration and Nutrition Monitoring policy reflects these best practices for:
- monitoring of fluid intake
- referral to the Registered Dietitian and Physician in relation to dehydration.

c) Once the policy is reviewed and if revisions are made, provide all direct care staff with education on the revised Hydration and Nutrition Monitoring Policy. The education provided shall be documented and include the name of the person providing the education, the date, name and sign off of the staff attending the education. These records will be kept in the home.

d) Implement the reviewed/revised Hydration and Nutrition Monitoring Policy.

e) Ensure that residents #001, #020 and #021's fluid intake is monitored and evaluated as per the revised Hydration and Nutrition Monitoring Policy.

Grounds / Motifs :

1. The licensee failed to ensure that the hydration program included the implementation of interventions to mitigate and the manage risks related to residents with low fluid intake.

The Hydration and Nutrition Monitoring policy stated that the nurse would review the electronic three Day Look Back Reports daily for undesirable intake trends and gaps over a 72-hour period. For residents drinking six servings or less of fluid for three consecutive days, the resident would be assessed for signs and symptoms of dehydration.

Staff had varying responses about the home's process for monitoring the fluid intake status of residents.

The Registered Dietitian shared that policies came from head office however, they were concerned about a resident's fluid intake status if the resident was consuming less than 1000 millilitres (8 units) in 24 hours for three consecutive days and not the 750 millilitres (6 units) in 24 hours for three consecutive days as written in the policy.

The Director of Care (DOC) shared that registered staff on the night shift would run the fluid look back report for seven days for all residents in the home. They would then review and record the number of days that the resident drank less than 8 units of fluid on the hydration monitoring tool, the specific room list and make a progress note. If the resident had consistent days where they drank less than 8 units this was to be noted in the progress notes. If registered staff wanted to know what days in the last seven days the resident drank less than 8 units, they could run the fluid look back report.

A RN shared the same as the DOC with the exception that they would not document the consistent days when the resident drank less than 8 units of fluid in the progress notes. They said they would document the number of days out of seven in red ink that the resident did not drink 8 units of fluid on the unit specific room list.

Another RN shared the same as the DOC, however stated that consistent days were not identified, it was just the number of days the resident drank less than 8 units in the past seven days that was recorded.

On two identified dates, a resident was recorded to have drank 7 units and 6 units of fluid respectively. A progress note stated that the resident had not met their fluid target two out of seven days that week. An RPN reviewed the progress note and stated that meant the resident drank less than 8 units two consecutive days.

On an identified date, a resident was marked as 2/7 for fluid intake on the unit specific room list. A RN said that meant that the resident drank less than 8 units on any two days in the last seven days. Review of their fluid intake record showed that the resident drank less than 8 units of fluid on two consecutive days.

On an identified date, a resident was noted to be marked 2/7 for fluid intake on the unit specific room list. An RPN said that meant that the resident drank less than 8 units on any two days of the last seven days. Review of the resident's fluid intake record showed that the resident drank less than 8 units of fluid on the previous two consecutive days.

As there was no consistent understanding of the fluid monitoring system for residents consuming less than 8 units of fluid on consecutive days, residents were placed at risk for becoming dehydrated.

Sources: Resident progress notes, point click care fluid look back reports, unit specific room lists, hydration monitoring tool, interviews with RD, DOC and other staff, Hydration & Nutrition Monitoring Policy.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to residents #001, #020 and #021 when their fluid intake was less than 1000 mls and staff did not know how consistent days of low fluid intake were to be monitored.

Scope: The scope is widespread as all three residents did not have their fluid intake monitored as per the home's policy.

Compliance History: In the last 36 months, the licensee was found to be non-complaint with O.Reg 79/10 s. 68.(2) and had one voluntary plan of correction issued to the home. (155)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2021

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s.229 (4) of O. Reg. 79/10.

Specifically the licensee must:

a) Ensure that residents are encouraged, reminded or assisted to perform hand hygiene before and after their meals and snacks.

b) Ensure that residents receiving tray service are encouraged, reminded or assisted to perform hand hygiene before and after their meals and snacks.

Grounds / Motifs :

1. The licensee failed to ensure that staff participated in the implementation of the home's infection control program when they failed to offer or perform hand hygiene for residents before meals.

The home's hand hygiene policy stated that staff were to wash resident's hands before and after eating.

A PSW was assisting a resident with the set up of their lunch tray and did not offer nor perform hand hygiene for the resident prior to the resident eating.

One day at lunch service, three residents were not offered nor was hand hygiene performed prior to the residents eating. On another day at lunch service, two residents were not offered nor was hand hygiene performed prior to them eating.

The DOC stated that staff were expected to perform hand hygiene for residents prior to and after eating.

Sources: Observations, interviews with PSW, DOC, record review of the Hand Hygiene policy.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm when residents were not offered hand hygiene prior to their meal.

Scope:The scope of this non-compliance was a pattern because hand hygiene was not offered to six out twelve residents observed.

Compliance History: This subsection was issued as a compliance order was issued July 7, 2020, during inspection 2020_781729_0005 with a compliance due date of July 7, 2020. A voluntary plan of correction (VPC) was also issued in the past 36 months.
(729)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 23, 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:

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

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 8th day of July, 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