Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 18, 2023	
Inspection Number: 2023-1142-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: 2063412 Ontario Limited as General Partner of 2063412 Investment LP	
Long Term Care Home and City: Creedan Valley Care Community, Creemore	
Lead Inspector Kim Byberg (729)	**Inspector Digital Signature**
Additional Inspector(s) Blake Webster (000689)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
May 3 – 5, 9 – 11, 15, 2023.

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00018977, related to an injury resulting in a significant change in health status;
- Intake: #00086054, related to an allegation of staff to resident abuse.

The following intake(s) were completed in this complaint inspection:

- Intake: #00084628 - related to pain and palliative care concerns.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care
Reporting and Complaints
Pain Management

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Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from emotional abuse by a Personal Support Worker (PSW).

Section 2 (1), of the Ontario Regulation 246/22 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Rationale and Summary
A resident was emotionally distraught when they were told by a PSW they could not call for assistance.

The homes investigation substantiated that abuse had occurred by a PSW towards a resident.

When a PSW used intimidating actions towards a resident, it resulted in them being emotionally impacted by the incident.

Sources
Resident progress notes, Critical Incident Report, the homes investigation notes, Abuse and Neglect Policy VII-G-10.00, revised October 2022. Interview with a resident, DRP, and PSW's.

[000689]

WRITTEN NOTIFICATION: Palliative Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (4) (b)

The licensee failed to ensure that based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident included, at a minimum, symptom management related to a resident.

Rationale and Summary
A complaint was received to the Ministry of Long-Term Care (MLTC) related to ineffective palliative care and symptom management of a resident.

The home's Nurse Practitioner (NP) and Physician wrote palliative care symptom relief orders and revised the orders as the resident's condition deteriorated.

The resident was ordered routine and pro re nata (PRN) medications for pain control and other palliative symptoms to be administered routinely and every thirty minutes as needed.

In the days before the residents' end of life, their pain was assessed to be between three and seven out of ten and their respiratory rate was elevated and ranged from thirty to thirty-four breaths per minute. The documentation of the effectiveness of the medication was not always effective. The registered staff administered routine medications; however, they did not consistently utilize other palliative medications available to them or notify the NP or Physician to assist in controlling the residents exacerbation of symptoms.

The RPN stated when they re-evaluated the effectiveness of the analgesic, they would complete the pain assessment in the electronic medical record (eMAR) and would use the same assessment to document the effectiveness of the resident's respiratory status. They stated that when the resident's respiratory rate was below thirty breaths per minute, they considered that to be effective.

Failure to assess, manage, and communicate with the NP or physician for the resident symptoms according to the palliative care orders may have resulted in prolonged dyspnea symptoms for the resident.

Sources: Record review of the residents' progress notes, eMAR, PAINAD assessments, Pain Study Tool, Plan of Care, Pain and Symptom Management Policy VII-G-30.30, last revised April 2019. Interview with RPN, ADOC and complainant.
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