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

Public Report

Report Issue Date: October 30, 2025
Inspection Number: 2025-1142-0004
Inspection Type: Complaint
Licensee: 2063412 Ontario Limited as General Partner of 2063412 Investment LP
Long Term Care Home and City: Creedan Valley Community, Creemore

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 24, 25, 2025 and October 1, 2, 7-9, 14-17, 22, 23, 29 and 30, 2025.
The inspection occurred offsite on the following date(s): September 29, 2025 and October 3, 20, 21, 24, 27 and 28, 2025.

The following intake(s) were inspected:
-Intake 00153618 and 00157099 related to multiple care concerns regarding a resident.

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

Continence Care
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to be treated with respect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

Residents expressed dissatisfaction of having to eat their meals and snacks off of disposable dishes with plastic cutlery. This practice provided challenges for them, had been going on for some time and they felt is was unacceptable.

Sources: interviews with residents, observations of meals and snacks

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

A resident was provided their food during a meal but it was not provided as specified in their plan of care.

Sources: resident clinical records.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The home's prevention of abuse policy was not complied with when an incident of abuse was reported.

Sources: Prevention of Abuse & Neglect of a Resident policy, homes investigation notes and interview with the Director of Care.

WRITTEN NOTIFICATION: Police record checks

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 81 (2)
Screening measures
s. 81 (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age.

A staff member started their employment in the home and worked for multiple months without providing a police record check.

Sources: interview with Office Manager, staff member, review of employee file.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
ii. a breakdown of major equipment or a system in the home,

The Director was not informed within one business day of an environmental hazard that affected the provision of care or well-being of one or more residents for a period greater than six hours when there was a breakdown in the dishwasher. The hot water system in the home was not able to maintain the dishwasher temperature at the proper temperature.

Sources: Review of Critical Incident Reports submitted by the home, Food Safety Inspection Report, interview with Executive Director.

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The Diabetes Management-Hypoglycemia policy and Diabetes Management-Hypoglycemia Care of the Conscious Resident who is Experiencing Hypoglycemia guidelines were not implemented for a resident.

Sources: resident clinical records, Diabetes Management-Hypoglycemia Policy, Diabetes Management-Hypoglycemia Care of the Conscious Resident Who is Experiencing Hypoglycemia; interviews with DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident was not administered their topical medication on three identified dates as specified by the prescriber.

Sources: Resident clinical records, CareRX daily shipping report, interview with Director of Care.

WRITTEN NOTIFICATION: Construction, renovation, etc,. of homes

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.

Construction, renovation, etc., of homes

s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:

1. Alterations, additions or renovations to the home.

The Nurse Call System was installed and implemented at the home to replace the previous resident-staff communication and response system (RSCRS). This was done without receiving the approval of the Director.

Sources: Interview with Executive Director.

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Create a case study regarding the identified incident. The case study must include the definitions of abuse as per Ontario Regulation 246/22 s. 2(1).
b) Educate the identified staff utilizing the case study developed. The education must include a written knowledge test completed by the identified staff.
c) The education record must be documented to include the written education, knowledge test, signatures of the identified staff, the title of the person providing the education, and the date the education was completed. A copy of the education and supporting documents must be kept in the home.
d) Complete an audit of employee files to ensure that all employees have a police record check. The audit shall include the date of the audit, employee's name, if police record check is in their file, if any deficiencies what action was taken, and the name of the person completing the audit.
e) Complete an audit of residents currently residing in the home that require a specific intervention with their food. If there are any residents that currently reside in the home that require the specific intervention with their food complete an audit during a meal when there is a specific type of food served. The audit shall include the date, the resident's name, the meal, the food served, if it was served appropriately, any deficiencies identified, corrective actions taken, and the name of the staff completing the audit.
f) Complete a review of how the home will ensure that they obtain reports for residents that have been sent to the hospital and how these will be communicated

to the physician/NP for follow up. This review will be documented and include the date, who was involved in the review, the outcome, and any changes to current processes implemented. The review shall be kept available in the home.
g) Develop a plan to ensure that any resident who is refusing to eat as a result of a change to their diet is reassessed by the Registered Dietitian and interventions are put in place to ensure that the resident is receiving adequate food and fluids. The resident and the substitute decision maker shall be consulted regarding interventions that could assist in improving the residents food and fluid intake.
h) Educate all registered staff on the Diabetes Management-Hypoglycemia Policy, Diabetes Management-Hypoglycemia Guidelines and Diabetes Management-Hypoglycemia-Care of the Conscious Resident who is Experiencing Hypoglycemia.

Grounds

A) As per Ontario Regulation 246/22 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, 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.
"Verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being or self-worth, that is made by anyone other than a resident.

A resident was not protected from verbal/emotional abuse by a staff.

Sources: review of critical incident report, the homes investigation notes, resident clinical record, interviews with PSWs and Director of Care.

B) As per O.Reg. 246/22 s. 7. neglect means the failure to provide a resident with the treatment, care, services or assistance required for healthy, 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.

i) A resident was sent to hospital and discharged back to the home with specific instructions to follow-up with their physician. The physician was not advised in a timely manner.

ii) A resident was provided their food during a meal but it was not provided as specified in their plan of care resulting in an incident requiring an intervention. A dietary referral was sent and nursing placed the resident on a specific diet until the resident could be assessed by the Registered Dietitian (RD).

Over a month, an incident of neglect occurred in which the resident continued to decline.

The resident not being followed-up after being seen in the hospital may have contributed to two identified incidents. Not ensuring that the resident had their food provided as specified in their plan of care resulted in an incident requiring intervention. The resident's diet changed and a decline in eating was noted after the change. There was no action taken to reassess the resident's diet. The inaction resulted in the resident being sent to hospital. The resident passed away .

Sources: Resident clinical records, Hydration & Nutrition Monitoring Policy, Diabetes Management-Hypoglycemia Policy, Diabetes Management-Hypoglycemia Guidelines, Diabetes Management-Hypoglycemia-Care of the Conscious Resident who is Experiencing Hypoglycemia, interviews with PSWs and Director of Resident Care.

This order must be complied with by December 29, 2025

COMPLIANCE ORDER CO #002 Communication and response system

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(f) clearly indicates when activated where the signal is coming from; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Develop and implement written procedures to direct staff on their role when there is a malfunction with any part of the resident-staff communication response system (RSCRS), or lack of RSCRS equipment. The written procedures shall include but not be limited to information on how the staff will be alerted to which resident is calling for staff assistance.
b) Provide education to all staff who use or maintain the RSCRS system on these written procedures. The education is to be documented including dates, name of persons in attendance and what was covered. The documentation is to maintained at the home.
c) Ensure that each care staff and nurse working has a working phone for the RSCRS and that the staff carry them when working.
d) Provide education to all staff who use the devices, with regard to how to use the device, what setting the phone is to be on, directions for charging the device or

changing batteries (if so required), and who to notify of any malfunction in the device. The education is to be documented including dates, name of persons in attendance and information reviewed. The documentation is to be maintained in the home.
e) As per the Call Bell Response policy, use the call bell audit software to audit response times no less than monthly on each resident home area/neighbourhood to ensure that call bells will be responded to promptly.
f) Complete an audit at least once daily on different shifts for a minimum of two weeks or until no deficiencies are noted, that includes the name of each care staff and nurse working, if they have a working phone on them at the time of the audit, if they do not have a phone on them that is working the reason for that and any actions taken to correct. The audit will include the date, time deficiencies and corrective action taken and the name of the staff completing the audit.
g) Contact the company that sends the emails titled 3400 Sienna - Creedan Valley SARA Daily System Status to obtain a written explanation of what the report is showing/meaning so that the Director of Care, Director of Environmental Services and Executive Director understand the report and possibly utilize it as an ongoing report to improve call bell response times.

Grounds

The resident-staff communication and response system when activated did not clearly indicated where the signal was coming from.

Rationale and Summary:

The Ministry of Long-Term Care (MLTC) received a compliant regarding the resident-staff communication and response system.

While the Inspector was walking in the hallway, a resident was calling for assistance. The resident activated the resident-staff communication and response system. Staff were observed to go by the room however, they were not aware that the resident-staff communication and response system was activated. Twenty-three minutes after the system was activated, the inspector spoke with the PSW and no call had gone to the phone that they were carrying. Another PSW was not carrying a phone as that phone was missing.

Residents shared that they had activated their call bell (RSCRS) and there was a long delay before assistance was being provided as staff have told them they do not get the notifications. The residents were fearful that when they need assistance, staff would not respond.

The inspector activated the resident-staff communication and response system in a resident room. Three PSWs, RPN and ADOC were observed to be in that hallway and no one acknowledged that the system was activated. After thirty-eight minutes the call was answered.

Staff shared multiple issues regarding the new resident-staff communication and response system, such as phones not being charged, missing phones and not having enough phones. They stated that they if they did not have a phone, they did not know who was calling for assistance. They also reported issues with the phones being put on silent mode, and with the screens showing "searching".

Failure to ensure that the resident-staff communication and response system clearly indicated when activated where the signal was coming from contributed to increased resident anxiety and delayed resident care.

Sources: Observations, interviews with residents, staff members, Director of

Environmental Services, Director of Care, Executive Director, review of email titled Creedan Valley SARA Daily System Status, Daily Roster, Nurse Call System Policy, Call Bell Response Policy.

This order must be complied with by January 12, 2026

COMPLIANCE ORDER CO #003 Food production

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (6) (c)
Food production
s. 78 (6) The licensee shall ensure that the home has,
(c) institutional food service equipment with adequate capacity to clean and sanitize all dishes, utensils and equipment related to food production and dining and snack service. O. Reg. 246/22, s. 78 (6).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:
a) That the booster is installed at the dishwasher so that the temperature can be maintained at a minimum of 60 degrees Celsius.
b) That if there is a breakdown in the system that causes the dishwasher to be out of service for a period greater than six hours that it is reported within one business day to the Director.

Grounds

The licensee failed to ensure that the dishwasher had the capacity to clean and sanitize all dishes, utensils and equipment related to food production and dining and

snack service.

Rationale and Summary

From August 2025 to October 9, 2025, the low temperature dishwasher was not being utilized to clean and sanitize the dishes and utensils related to dining and snack service. Residents were served their meals and snacks on disposable paper dishes and plastic utensils.

The Director of Dietary Services shared that a booster needed to be installed at the dishwasher to maintain the water temperature. The Director of Environmental Services shared an electrical outlet needed to be installed by the dishwasher to power the booster and that work had not yet been completed.

Failure to ensure that the water temperature was adequate for the low temperature dishwasher, the dishwasher did not have the capacity to clean and sanitize all dishes, utensils and equipment related to food production and dining and snack service. This resulted in the residents being served their meals and snacks on disposable paper dishes and plastic utensils for an unacceptable period of time.

Sources: Observation of meals, interviews with residents, PSWs, RPNs, Director of Dietary Services, Director of Environmental Services, Director of Care, review of Dishwasher Temperature Records, Dishwasher Temperature Record Policy, Simcoe Muskoka District Health Unit -Food Safety Inspection Report and purchase order emails for booster.

This order must be complied with by November 28, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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