Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Karen Simpson
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 □ Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 X Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	
Licensee:	Autumnwood Mature Lifestyles Communities Inc.
LTC Home:	Cedarwood Lodge
Name of Administrator:	Rudy Putton

Background:
The licensee of Cedarwood Lodge ("the home") is currently in non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) and has a history of ongoing non-compliance with the *Long-Term Care Homes Act, 2007* and Ontario Regulation 79/10 ("the Regulation") since the home opened in May 2015. There have been repeated non-compliance including but not limited to ongoing issues with providing resident care, protecting residents from abuse, not following plans of care, not meeting reporting obligations to the Director, and not managing responsive behaviours. Cedarwood Lodge is a long-term care home in Sault Ste. Marie and is licensed for 50 interim beds. A license was issued to the licensee in May 2015 for a 5-year term. Section 156 (1) of the LTCHA states that the Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home (Mandatory Management Order).

Section 156(2) of the LTCHA states that an order may be made under this section if (a) the licensee has not complied with a requirement under the LTCHA; and (b) there are reasonable grounds to believe that the licensee cannot or will not properly manage the long-term care home or cannot do so without assistance. Requirement under the Act [LTCHA] is defined in s. 2 of the LTCHA as a requirement contained in the LTCHA, in the regulations or in an order or agreement made under the LTCHA, and includes a condition of licence issued under the LTCHA.

The Director is issuing this Mandatory Management Order because the licensee has not complied with a requirement under the LTCHA and the Director has reasonable grounds to believe that the licensee cannot properly manage the long-term care home. This belief is based on the licensee's ongoing and persistent non-compliance with requirements under the LTCHA, a history of issuing multiple and repeat Compliance Orders, the licensee's failure to comply with Compliance Orders, a direction to the placement coordinator to cease admissions made on two separate occasions, and the instability with the management of the home.

Order:	

To Autumnwood Mature Lifestyles Communities Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to: *Long-Term Care Homes Act, 2007*, S. O. 2007, c. 8, s. 156(1). The Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home.

Order: Autumnwood Mature Lifestyles Communities Inc. ("the licensee") is ordered:

(a) To retain a person described in paragraph (c) or (d), where applicable, of this Order to manage Cedarwood Lodge located at 860 Great Northern Road, Sault Ste. Marie, Ontario ("the long-term care home");

(b) To submit to the Director, LTC Inspections Branch (LTCIB) within **7 calendar days** of being served with this Order a proposed person described in paragraph (a) to this Order;

(c) the person described in paragraph (a) to this Order must be acceptable to the Director and approved by the Director, LTCIB in writing;

(d) if the licensee does not submit a proposed person described in paragraph (a) to this Order to the Director, LTCIB within the time period specified in paragraph (b) to this Order, the Director, LTCIB may select a person that the licensee must retain to manage the long-term care home

(e) the person described in paragraph (a) to this Order acceptable to the Director, LTCIB will have specific qualifications, including:

(i) the experience, skills and expertise required to operate and manage a long-term care (LTC) home in Ontario and to maintain compliance with the *Long-Term Care Homes Act,* 2007 and O. Reg. 79/10;

(ii) have a Good Compliance Record, which for the purpose of this Order means the LTC home for which the person described in paragraph (a) to this Order is a licensee or manager, or to which the person described in paragraph (a) to this Order provides consulting services has a compliance record under the LTCHA that is considered to be substantially compliant including:

1. critical incidents that occur are reported as required;

2. complaints are managed effectively in the LTC home;

3. the LTC home develops policies/procedures using evidence-based practices and quality strategies;

4. the LTC home responds to compliance issues identified during Ministry inspections; and

5. non-compliance in areas of actual harm or high risk of harm to residents and any other person identified during inspections are rectified within the time frame required by the Ministry.

(iii) demonstrate that they have not, under the laws of any province, territory, state or country, in the three years prior to this order,

1. been declared bankrupt or made a voluntary assignment in bankruptcy;

2. made a proposal under any legislation relating to bankruptcy or insolvency; or

3. have been subject to or instituted any proceedings, arrangement, or compromise with creditors including having had a receiver and/or manager appointed to hold his, her, or its assets.

(f) to submit to the Director, LTC Licensing and Policy Branch (LPB) a written contract pursuant to section 110 of the LTCHA **within 7 calendar days** of receiving approval of the Director, LTCIB pursuant to paragraph (c) of this Order or where the Director exercises discretion and selects a person pursuant to paragraph (d) of this Order;

(g) to execute the written contract **within 24 hours** of receiving approval of the written contract from the Director, LPB pursuant to section 110 of the *Long-Term Care Homes Act,* 2007 and to deliver a copy of that contract once executed to the Director, LPB;

(h) to submit to the Director, LTCIB a management plan, prepared in collaboration with the person described in paragraph (a) to this Order, to manage the long-term care home and that specifically addresses strategies to achieve compliance with those areas identified in the Grounds to this Order as being in non-compliance **within 30 calendar days** of receiving approval of the Director, LTCIB pursuant to paragraph (c) of this Order or where the Director exercises discretion and selects a person pursuant to paragraph (d) of this Order;

(i) the person approved by the Director, LTCIB pursuant to paragraph (c) to this Order or the person selected by the Director, LTCIB where the Director exercises discretion pursuant to paragraph (d) of this Order shall begin managing the home in accordance with the written contract described in paragraph (g) to this Order **within 24 hours** of the execution of that written contract;

(j) the management of the home by the person described in paragraph (a) to this Order is effective until advised otherwise by the Director, LTCIB; and

(k) any and all costs associated with complying with this Order are to be paid for by the licensee, including for certainty, but not limited to, all costs associated with retaining the person described in paragraph (a) to this Order.

Grounds:
Autumnwood Mature Lifestyles Communities Inc. ("the licensee") is licensed to operate a long-term care home known as Cedarwood Lodge located at 860 Great Northern Road, Sault Ste. Marie, Ontario ("Cedarwood Lodge" or "the home").

Serious and ongoing non-compliance with requirements under the LTCHA, as referred to in detail below, continues to occur at Cedarwood Lodge. Given the seriousness of the compliance issues, on March 28, 2017, I directed the placement coordinator to cease admissions to the home on March 28, 2017. This Mandatory Management Order is now being made as the licensee has not complied with a requirement under the LTCHA and I have reasonable grounds to believe that the licensee cannot properly manage the home. The performance of the licensee in ensuring and sustaining compliance with the requirements under the LTCHA has diminished significantly affecting the quality of care and quality of life of residents in the home.

Cease of Admissions

The home opened on May 19, 2015. Within days of the home opening, the Ministry received multiple complaints from staff and community members. Inspections were conducted on May 29, 2015. The findings from the inspections led me to believe that there was a risk of harm to the health or well-being of residents or persons who might be admitted as residents to the home. Due to this belief, on May 29, 2015, I directed the placement coordinator pursuant to section 50 of the LTCHA to cease admissions to the home.

The most concerning areas of non-compliance that formed the basis for the cease of admissions were:

- Plans of care were not completed for all residents.
- Resident admission assessments were not completed.
- Medications for some residents were not available in the home.
- Staff were not completing medications administration, and residents were not receiving medications due to insufficient time allocated for medication administration.
- There was insufficient staff to meet the needs of the residents.
- Skin assessments and wound care treatments were not being completed.
- Staff were concerned that they were not aware of residents' care requirements as plans of care were not available to direct care staff.
- There were several residents with restraint devices although there were no orders for the use of restraints and no direction had been provided to staff on how to use the restraints.

On September 9, 2015, the cease of admissions was lifted after the licensee was found to have addressed these compliance concerns.

On March 28, 2017, for the second time in less than 2 years, I directed the placement coordinator pursuant to section 50 of the LTCHA to cease admissions to the home. This cease of admissions was issued because the findings from a Resident Quality Inspection that was conducted October 31, November 4, 7-10 and 14-18, 2016 led me to believe that there was a risk of harm to the health or well-being of residents or persons who might be admitted as residents to the home.

This cease of admissions was based on a significant number of findings of non-compliance with

requirements under the LTCHA including, but not limited to:

1) The licensee failed to protect residents from abuse by:
   (a) Failing to take required and appropriate action after all staff identified a resident with previous history of inappropriate sexual behaviours;
   (b) Failing to report to the Director suspected or alleged abuse;
   (c) Failing to notify the Substitute Decision Maker of residents who have been involved in suspected or alleged abuse; and
   (d) Failing to notify the appropriate police force of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.
2) Plans of care were not developed and implemented in collaboration with staff and others involved in the different aspects of care of the resident so that they are consistent with and complement each other.
3) Care set out in the plan of care was not provided to the resident as specified in the plan.
4) An incident of a resident who caused physical injury to another resident through aggressive behaviours. The resident who caused the injury was not properly assessed for responsive behaviours or cared for because the licensee failed to follow up with external resources; and
5) The licensee has not ensured that the home's falls prevention and management as well as skin and wound care programs meet the requirements as identified in the LTCHA and the Regulation.

The cease of admissions is currently in effect.

Other Enforcement Actions

More than 20 inspections have been conducted since the home opened on May 19, 2015. Reports and orders from these inspections were issued on the following dates:

1) June 3, 2015, Complaint Inspection # 2015_380593_0016 (A1), one written notification, including one compliance order.
2) June 18, 2015, Other Inspection # 2015_281542_0010 (A1), two written notifications, including one voluntary plan of corrective action and two compliance orders.
3) June 25, 2015, Other Inspection # 2015_246196_0010, five written notifications, including two voluntary plans of corrective action.
4) July 22, 2015, Follow-up Inspection # 2015_281542_0012, five written notifications, including three voluntary plans of corrective action and two compliance orders.
5) August 7, 2015, Critical Incident Inspection # 2015_395613_0012, three written notifications.
6) August 14, 2015, Complaint Inspection # 2015_281542_0013, five written notifications, including three voluntary plans of corrective action and one compliance order.
7) September 28, 2015, Complaint Inspection # 2015_339617_0018, six written notifications, including four voluntary plans of corrective action.
8) September 30, 2015, Critical Incident Inspection # 2015_339617_0017, one written notification, including one voluntary plan of corrective action.
9) December 15, 2015, Follow-up Inspection # 2015_281542_0022, one written notification, including one compliance order.
10) December 22, 2015, Critical Incident Inspection # 2015_281542_0021, four written notifications, including four voluntary plans of corrective action.
11) December 22, 2015, Complaint Inspection # 2015_281542_0020 (A1), three written notifications, including two voluntary plans of corrective action and one compliance order.

12) January 20,2016, Complaint Inspection # 2015_395613_0021, seven written notifications, including five voluntary plans of corrective action.
13) February 4, 2016, Critical Incident Inspection # 2015_395613_0022, seven written notifications, including seven voluntary plans of corrective action.
14) February 24, 2016, Resident Quality Inspection # 2016_281542_0003, 12 written notifications, including four voluntary plans of corrective action and three compliance orders.
15) June 22, 2016, Complaint Inspection # 2016_463616_0013, two written notifications, including one compliance order.
16) June 22, 2016, Follow-up Inspection # 2016_463616_0012, two written notifications, including one compliance order.
17) June 27, 2016, Other Inspection # 2016_339617_0020, one written notification.
18) June 27, 2016, Critical Incident Inspection # 2016_339617_0019, one written notification, including one voluntary plan of corrective action.
19) February 21, 2017 (amended April 4, 2017), Resident Quality Inspection # 2016_395613_0019 (A1), 16 written notifications, including nine voluntary plans of corrective action, six compliance orders and one Director's referral.
20) April 12, 2017, Inspectors started conducting weekly inspections.
21) April 26, 2017, Follow-Up Inspection # 2017_395613_0007, three written notifications, including two voluntary plans of corrective action.
22) May 1, 2017, Other inspection # 2017_616542_0008, one written notification, including one compliance order, with a compliance due date of May 6, 2017.
23) May 1, 2017, Complaint inspection #2017_624196_0008, commenced and the report is pending.
24) May 1, 2017, Follow-up Inspection # 2017_24196_0007, commenced to follow up remaining five orders. Ministry inspectors found continued non-compliance and have determined that one of the five orders will be reissued.

The key areas of non-compliance with Orders include, but are not limited to the following:

1) **24-hour Nursing Care – LTCHA, s. 8 (3)** – The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

- On May 1, 2017 a compliance order was issued during Other Inspection # 2017_616542_0008. Although there was no previous non-compliance history for this specific subsection, the decision to issue an order was based on the severity and scope of the non-compliance because inspectors found that a registered nurse was not present in the home for seven hours of one 12 hour shift and an entire 12 hour shift on three different days. The compliance date for this order is May 6, 2017.

2) **Plan of Care – LTCHA, s. 6(4)(a**) – The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were intergraded and consistent with, and complemented each other.

- On February 21, 2017, a compliance order was issued during Resident Quality Inspection #2017_395613_0019 (A1). Although there was no previous non-compliance history for this specific subsection, the decision to issue an order was based on the severity of the non-compliance as actual harm or risk of harm occurred to multiple residents. Staff were not communicating with the

attending physician regarding wound care and had changed the physician orders without direction from the physician. There was also a breakdown in communication from wound specialists to front line staff and physician orders were not implemented.

- The order pursuant to s. 153 (1) (b) of the LTCHA required the licensee to develop, submit and implement a plan that includes the following: 1. A process to ensure that all physician's orders are followed and when there is a change in a resident's wounds that the Physician (Medical Director) is notified. 2. A process to ensure that staff and others involved in the different aspects of care of three specified residents and all other residents, collaborate with other members of the care team, including the Medical Director and Physician Assistant to maintain effective communication regarding the status of resident's wounds, so that their assessments are integrated and are consistent with and complement each other. 3. A process to ensure that the home maintains effective communication between the Wound Care Specialist, Physician, Medical Director, Physician Assistant, Nurse Practitioner or any other resources who are part of the interdisciplinary team for each resident. This plan shall also include specified time frames for the development and implementation and identify the staff member(s) responsible for the implementation. This plan shall be submitted, in writing, to Lisa Moore, Long-Term Care Homes Inspector, Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury ON P3E 6A5, by email at SudburySAO.moh@ontario.ca. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133. This plan must be submitted to the Ministry and fully implemented by April 28, 2017.

- Follow up inspection #2017_624196_0007, commenced on May 1, 2017, Ministry inspectors determined that the licensee did not comply with this order and it will be reissued.

3) Plan of care – LTCHA, s. 6(7) – The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

- On August 14, 2015, a voluntary plan of correction was issued during Complaint Inspection # 2015_281542_0013.

- On September 28, 2015, a voluntary plan of correction was issued during Complaint Inspection # 2015_339617_0018.

- On December 22, 2015, a voluntary plan of correction was issued during Critical Incident Inspection # 2015_281542_0021.

- On February 24, 2016, a voluntary plan of correction was issued during Resident Quality Inspection # 2016_281542_0003.

- On June 27, 2016, a voluntary plan of correction was issued during Critical Incident Inspection # 2016_339617_0019.

- On February 21, 2017, a compliance order was issued during Resident Quality Inspection# 2016_395613_0019 (A1). The decision to issue an order was based on a pattern of potential for actual harm to residents, as well as a long standing history of non-compliance with this subsection. Since the home opened in May 2015, the licensee has had continued non-compliance with this

requirement. The order pursuant to s. 153 (1)(a) of the LTCHA required the licensee to: 1. Develop and implement a process to ensure that for three specified residents and all residents that the care set out in the plan of care is provided as specified in the plan. 2. Develop and implement processes to ensure the Medical Director and Physician Assistant's orders are followed and not changed by registered staff. 3. Ensure audits are done on the above processes and records kept. This order is to be complied with by April 28, 2017.

Management of the Home

- A temporary five-year licence was issued to the licensee with an effective date of May 19, 2015. A term and condition of the licence required the licensee to have a management company in place due to the licensee's lack of experience operating a long-term care home. Specifically, the licensee was required to have a fully executed management contract, with a term of at least one calendar year, in place at the time of the effective date of the temporary licence.

- The licensee entered into a management contract with Sienna Senior Living to provide management services. The contract was approved by the Director, Licensing and Policy pursuant to s. 110 of the LTCHA.

- On May 24, 2016, the management agreement between Sienna Senior Living and the Licensee was terminated.

- On June 6, 2016, I approved a proposal that would allow the licensee to terminate their management contract with Sienna Senior Living and self-manage the home. I also required the licensee to enter into an agreement with another long-term care home, approved by the Director, to provide support to Cedarwood Lodge by telephone as necessary and to answer questions.

- On August 1, 2016, I approved a Memorandum of Understanding (MOU) between the licensee and Extendicare Kirkland Lake to provide support to Cedarwood Lodge.

- During a Resident Quality Inspection (RQI) conducted in October 2016 (# 2016_395613_0019), the Executive Director / Director of Care told Ministry Inspectors that she was not aware of an agreement with another LTC home to provide support to Cedarwood Lodge. Inspectors also found that none of the staff had utilized the other home's services under the MOU even though the licensee continued to have serious compliance issues as identified in the RQI.

- On April 18, 2017, the home told the Inspector conducting a follow-up inspection (# 2017_395613_0007) that the home's Administrator and Director of Care would both be away from the home for a three month period. On April 21, 2017 during a weekly meeting with the licensee, they were requested to submit to the Ministry a staffing plan detailing how the licensee would ensure it would have an Administrator and Director of Care that met the requirements of the Regulation, s. 212 and s. 213. On April 23 and 25, 2017, the licensee submitted an interim plan setting out how they intend to meet the Administrator requirements and the Director of Care requirements in s. 212 and s. 213, as well as resumes of the staff currently back filling both the Director of Care and Administrator positions.

There are serious concerns about the inconsistency of the management of this home. As of May 4, 2017 there has not been a hired Acting Administrator or a hired Acting Director of Care in the home since April 18, 2017, but the Resident Quality Manager is filling the role of Administrator and other current staff members have been filling the role of Director of Care. The persons that are currently performing these roles do not fully meet the requirements of the positions. The unstable leadership team and lack of consistent experienced management resources in the home is putting resident care at serious risk.

This order must be complied with by:	The dates as outlined and specified in the Order.

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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

Issued on this 9th day of May, 2017.	
Signature of Director:	
Name of Director:	Karen Simpson

Version date: 2017/02/15