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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Amended Public Copy/Copie modifiée 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
Jan 27, 2020	2019_781729_0018 (A2)	012214-19, 012218-19, 012220-19, 012225-19, 012227-19, 012231-19, 013566-19, 013567-19, 014068-19, 014957-19, 017629-19	Follow up

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

Amended by SHARON PERRY (155) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date for compliance order #003 has been changed from January 31, 2020 to February 14, 2020 as requested by the Licensee.

Issued on this 27th day of January, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by SHARON PERRY (155) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 2019.

-Log #012214-19, follow up to compliance order (CO) #001, 2019_773155_0007 related to residents right to privacy;

-Log #012218-19, follow up to CO #005, 2019_773155_0007 related to the home, furnishings and equipment being kept clean and sanitary;

-Log #012220-19, follow up to CO #007, 2019_773155_0007 related to residents being protected from abuse by anyone and not being neglected;

-Log #012231-19, follow up to CO #011, 2019_773155_0007 related to assessments necessary to develop the initial plan of care;

-Log #012225-19, follow up to CO #013, 2019_773155_0007 related to residents bathing;

-Log #012227-19, follow up to CO #015, 2019_773155_0007 related to responsive behaviours;

-Log #013566-19;

-Log #013567-19;

-Log #014068-19;

-Log #014957-19;

-Log #017629-19, related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with Director of Operational Effectiveness (DOOE), Director of Quality and Informatics (DOQI),

Executive Director (ED), Director of Care (DOC), Associate Director of Care/RAI Coordinator (ADOC), Scheduling Coordinator, Sienna Quality Partner, Office Manager, Clinical Care Partner, Director of Resident Programs (DORP), Director of Dietary Services (DDS), Registered Nurses, Registered Practical Nurses, Personal Support Workers, Care Support Assistant (CSA), Resident Service Coordinator (RSC), Nexium Agency PSW, Housekeeping, Medical Director, Residents and Families.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed meal service, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, employee files, education records, home's investigation notes; and observed the general maintenance, cleanliness, safety and condition of the home.

Inspector (754) Tawnie Urbanski was present during the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **10 WN(s)**
- **4 VPC(s)**
- **4 CO(s)**
- **3 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
O.Reg 79/10 s. 25. (1)	CO #011	2019_773155_0007	155
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2019_773155_0007	155

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to respond to responsive behaviours, actions were taken to respond to the needs of the residents, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

A) A Critical Incident System (CI) report was submitted to the Ministry of Long Term Care (MOLTC) related to alleged physical abuse by resident #074 towards resident #073.

Resident #074 had a history of responsive behaviours directed towards co-residents. Resident #074's progress notes located in point click care (PCC) stated that on a specified date, resident #074 initiated an altercation with resident #073.

On three separate specified dates, progress note documentation stated resident #074 had verbal altercations with co-residents.

It was reported by a staff member that they witnessed resident #074 attempt to injure another resident. On another occasion resident #074 was witnessed in a physical altercation with another resident resulting in them being injured.

The Dementia Observation System (DOS) and thirty-minute monitoring form was

reviewed for resident #074 from altercations with co-residents. The assessment and monitoring forms were not completed for multiple shifts after verbal and physical altercations occurred. There was no documented follow up of a review of the DOS monitoring forms, assessments, and interventions implemented after the initial DOS monitoring tool was put in place.

PSW #120 and #133, RPN #124 and RN #134 stated that they referred to a resident's plan of care for direction related to behavioural interventions. Resident #074's plan of care did not identify any responsive behaviors, behavioural triggers, or interventions implemented to assess, monitor or evaluate resident #074 until several months after the resident was admitted to the home and had multiple altercations with co-residents.

PSW #133 shared that resident #074 preferred a quiet environment and found the noise of other residents difficult to ignore. They shared that they notified ADOC #102 and the BSO lead about the concerns with noise and the resident's behaviours in response, but nothing was done.

RPN #124 shared that resident #074 had specific triggers and that they had to intervene on more than one occasion when these triggers resulted in altercations between resident #074 and #073.

ADOC #102 stated that they were only aware of one specific responsive behaviour when the resident was admitted to the home.

At a care conference, resident #074 provided the team with one of their triggers. The plan of care was not updated to include the behavioural trigger identified at the care conference. ADOC #102 stated that prior to a specified date, they were not aware that resident #074's plan of care did not include responsive behaviours and the DOS charting and thirty-minute checks were incomplete.

The licensee failed to ensure that strategies were developed and implemented to respond to responsive behaviours, actions were taken to respond to the needs of resident #074, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

B) The licensee failed to take action to respond to the needs of resident #014 and #017 that included assessments and interventions and that the resident's responses to the interventions were documented.

A CI report submitted to the MOLTC alleged that on a specified date, resident #014 exhibited inappropriate behaviours towards resident #017.

Progress notes in PCC, stated that an incident occurred where resident #014 exhibited inappropriate behaviours towards another resident.

The home's policy titled "Sexual Expression and Intimacy" policy #VII-G-10.10 stated the nurse would, upon becoming aware of a resident request or observation of sexual expression by any resident, assess the situation. If unwanted sexual expressive behaviour occurred evidence of distress, injury or inappropriate for the surrounding environment, immediately intervene to ensure safety of residents and report to the Director of Care or nurse in charge.

Progress notes in PCC for resident #017, did not document that there had been an incident of alleged abuse between resident #014 and #017. There was no documentation of an assessment of resident #017 after the incident, nor was there any indication as to the resident's response to the incident.

There was no documentation in either the plan of care for resident #017 or resident #014 of any assessments or interventions the home put in place to keep resident #017 safe until four days after the incident occurred.

RPN #117 shared that no interventions were put into place as the incident was not documented and they did not know about it.

The licensee failed to take actions to respond to the needs of resident #014 and #017 that included assessments and interventions and that the resident's responses to the interventions were documented. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #008's plan of care stated that their preference was a tub bath twice weekly.

Resident #008's point of care (POC) bathing documentation for one month showed that the resident was not given their choice of a tub bath on four occasions and was not given a bath at all on one occasion.

Resident #008's progress notes and alerts for the specified one month, did not contain any notes or alerts regarding why the resident was not bathed according to their preference.

PSW #107 shared that resident #008 preferred to have a bath, however on a specified date, they gave resident #008 a shower.

RPN #117 shared there was no documentation as to why resident #008 was not given their choice of a tub bath on four occasions or why they missed a bath on one occasion and said there was no audit being done to ensure that residents were offered and received a minimum of twice weekly bathing according to their preference. [s. 33. (1)]

2. Resident #027's plan of care stated that their preference was a bath twice weekly, but to offer the resident a shower at that time because they had a medical condition.

Resident #027 shared that their bathing preference was a tub bath. They said they were never offered a shower but were given bed baths because of their medical condition.

Resident #027's POC documentation for bathing one month, showed they were given bed baths on eight occasions.

PSW #131 shared that resident #027 preferred to have a bath, however they were being given bed baths because they had a medical condition. They were not sure if the shower renovations were done, and had not had training on how to use the shower chair. [s. 33. (1)]

3. Resident #071's plan of care stated their preference was a tub bath twice weekly.

Resident #071 told inspector #155 that it had been over a week since they had a bath. Instead, they were given a shower where they were placed in a chair suspended over the tub and sprayed.

Resident #071's POC documentation for bathing for one month showed that on one occasion they had a sponge bath at the sink, on four occasions they had a shower and on two occasions they had a tub bath.

RPN #117 said there was no documentation as to why resident #071 was being given showers instead of tub baths, and there was no documentation as to why resident #071 did not have a bath on two occasions within a two week timeframe. [s. 33. (1)]

4. Resident #065 expressed concern to Inspector #738, that they had not received a bath in over a week. They preferred to have a tub bath twice a week, and had recently gone eight days without a bath.

Resident #065's POC documentation for bathing for one month showed resident #065 had a tub bath on five specified dates. On four specified dates resident #065 was given bed baths.

RPN #117 shared there was no documentation as to why resident #065 was given bed baths instead of tub baths on four specified dates.

The DOOE #101 and Quality Partner #115 shared that if a resident was not bathed according to their preference, or if the bathing activity did not occur, staff were to document this in a progress note, or they could create an alert.

Resident #008, #027, #071 and #065 were not bathed at a minimum of twice weekly according to their preference. [s. 33. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A) Resident #078's wheelchair was observed for three consecutive days, with stains on the arm rests and cushion. Crumbs were also noted on the frame of the wheelchair.

Resident #079's wheelchair was observed for three consecutive days, with cobwebs noted in the right wheel.

Review of the Monthly Equipment Cleaning Schedule for the home areas showed that resident #078 was not listed on the schedule to have their wheelchair cleaned. Resident #079's wheelchair was initialed as being cleaned on a specified date. The Monthly Equipment Cleaning Schedule showed that staff initialed that resident #078's wheelchair was last cleaned two weeks prior to the inspected dates.

PSWs #120 and #127 said that all staff were responsible for wiping up or cleaning any spills or stains on resident wheelchairs or walkers when observed, but resident equipment had a deep clean once monthly on night shift as per the Monthly Equipment Cleaning Schedule.

Director of Resident Programs (DORP) #132 shared that all staff were responsible to clean the resident equipment at the time they saw spills or noticed that the equipment was dirty. DORP #132 stated that they were responsible for updating the Monthly Equipment Cleaning Schedule. They reviewed the schedule and agreed that resident #078 was not on the Monthly Equipment Cleaning

Schedule for a specified month.

DORP #132 observed resident #078 and #079's wheelchairs and acknowledged that they were not clean.

The licensee failed to ensure that resident #078 and #079 had their equipment, specifically wheelchairs, kept clean and sanitary.

B) For three consecutive dates during the inspection, the following was observed:
-Cobwebs, dead insects and dust were in the window panes of resident rooms, and the library;
-Dust build up in the ceiling vent in the library and in the hairdressing/shower room vents;
-Fan at the nursing station, and the standing fan the TV room were dusty;
-Cobwebs and dirt build up behind the library door, behind fire doors by a resident room, by fire doors near the physio room, in a resident room by the closet door, in the corner of the hallway by specified resident rooms, and in the corner of Lounge;
-Cobwebs and dirt build up in the large dining room by the two doors leading to the outside;
-Dead insects noted in the fluorescent light covers in the physio room and around the perimeter of the physio room;
-Floor in the physio room was dirty and had not been buffed; and
-Dead insects noted in the ladder laying in the exit doors.

Director of Dietary Services (DDS) #135 and DOQI #118 acknowledged the above deficiencies. DDS #135 shared they had not yet received a duster that was ordered to clean between the window panes. Review of records showed that a Long Reach Flexible Duster was ordered on a date during the inspection.

DOQI #118 shared that since August 2019, Room/Common Area Audits were being done with each room/area being audited once a month. They stated that when a housekeeping deficiency was noted an email would be sent to the DDS.

Review of the Room/Common Area Audit done on a specified date, showed a room was audited and it was noted there were spider-webs in the window. The audit identified this concern was put into the Maintenance Care program for action.

The licensee failed to ensure that the home, furnishings, and equipment were kept clean and sanitary. [s. 15. (2) (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect resident #073 from abuse by resident #074.

Physical abuse as defined by the regulations includes the use of physical force by a resident that causes physical injury to another resident.

A CI submitted to the MOLTC reported an allegation of physical abuse by resident #074 towards resident #073 that occurred on a specified date.

On a specified date, night shift staff and RN #134 observed resident #073 asleep with signs of several injuries.

ADOC #102 was notified and telephone support was provided. RN #134 stated they thought the injuries were self-inflicted, so no investigation was completed.

PSW #133 shared with inspector #729, that resident #077 told them they witnessed an altercation between resident #074 and #073. PSW #133 immediately reported the incident to RN #113.

PSW #133, #120 and RPN #124 said that resident #074 had a history of verbal and physical aggression towards resident #073 since resident #074's admission. There had been other altercations between resident #074 towards two other residents. The staff said that resident #074's behaviours were triggered by some of resident #073's actions and they had informed the ADOC of this, but nothing was done about it.

Resident #074’s plan of care did not identify that the resident exhibited any responsive behaviours nor were there interventions in place despite documented incidents of verbal and physical aggression towards resident #073 and other residents, until three days prior to the physical altercation.

In an interview with resident #074 they stated that they knew what they had done was wrong and wished they had the common sense to leave people alone.

The licensee failed to protect resident #073 from physical abuse by resident #074. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensed failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, they immediately reported that suspicion and the information upon which it was based to the Director.

The home submitted a CI report to the MOLTC on a specified date. The CI report documented that resident #065's visitor observed a staff member allegedly abusing resident #065 four days before the CI was submitted.

DOOE #101 stated the home became aware of the allegation of abuse one day after it was observed, after they received an email from resident #065's visitor. They stated the home should have reported the incident at that time but did not do so until three days later.

The licensee failed to ensure that when a person who had reasonable grounds to suspect that abuse of resident #065 had occurred by anyone, they immediately reported that suspicion and the information upon which it was based to the Director.

[738] [s. 24. (1)]

2. A CI report submitted to the MOLTC on a specified date, stated resident #014 exhibited inappropriate behaviours towards resident #017.

A review of resident #014's progress notes in PCC showed documentation was completed as a late entry three days after the incident occurred.

DOQI #118 shared the team learned of the incident three days after it occurred, initiated an investigation, and the CI was not submitted until four days after the incident.

The license failed to immediately report to the Director when they had reasonable grounds to suspect that alleged sexual abuse occurred. [s. 24. (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 all staff have been trained and are aware to immediately report their suspicions and the information upon which it was based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident at risk for altered skin integrity received a skin assessment by a member of the registered nursing staff upon return from hospital.

Progress notes stated that on a specified date, resident #068 was transferred to the hospital after they had complications from a new medical condition.

RPN #114 and RPN #126 stated that residents identified to have altered skin integrity upon return to the home from hospital are required to have a skin assessment completed. RPN #124 stated this assessment would be documented under the assessments tab in PCC as a Skin and Wound Assessment. Review of these assessments, as well as resident #068's progress notes showed they did not complete a skin assessment until a specified date, almost 24 hours after the resident returned from hospital.

RPN #114 stated that resident #068's progress notes showed that a staff observed the resident, but no skin assessment had been completed. They said that this should have been done as soon as the resident came back to the home.

The licensee failed to ensure that resident #068 received a skin assessment by a member of the registered nursing staff upon return from hospital. [s. 50. (2) (a) (ii)]

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 when a resident at risk for altered skin integrity receives a skin assessment by a member of the registered nursing staff upon return from the hospital, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee failed to comply with the following requirement of the LTCHA: it is a condition of every license that the licensee shall comply with every order made under the Act.

On June 19, 2019, compliance order (CO) #011 from inspection number 2019_773155_0007(A1) was issued under O.Reg 79/10. s. 25(1):

The licensee must be compliant with s. 25(1) of O.Reg 79/10.
Specifically, the licensee must ensure that:
a) For all residents admitted to the home, that the assessments necessary to develop the initial plan of care are completed within 14 days of the resident's admission and that the initial plan of care is developed within 21 days of the admission.
b) Ensure an auditing process is developed and fully implemented to ensure that initial assessments and plans of care for residents are completed within the required time period identified in the regulations. This auditing process must be documented including when the audit took place, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken with regards to the audit results.

The compliance date was July 4, 2019.

The licensee completed step a) but failed to complete step b)

The DOQI #118 shared that the "Move In Checklist - Nurse", was used as the audit to ensure that assessments were completed within fourteen days and the

initial plan of care was developed within twenty-one days of the resident's admission. After each item listed on the checklist was completed it was to be dated and initialed. After day twenty-one, the checklist was to be given to the DOC or Designate and they were to review the audit to make sure that it was complete at which point they would sign off.

The Move In Checklist – Nurse, for resident #069, #071 and #080 identified there were no dates or initials on these checklists to show when the admission Minimum Data Set assessment (MDS) was completed or when the plan of care was completed. The DOC or Designate had not signed any of the Move In Checklist's. There were no documented results that showed what actions were taken with regards to the audit results.

The DOQI #118 acknowledged they did not have any documentation as to what actions were taken with regards to the audit results.

The licensee failed to comply with part b) of compliance order #011 made under the act. [s. 101. (3)]

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 when a compliance order is received, that the home with every aspect of the order made under the Act, to be implemented voluntarily.

WN #8: 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 failed to ensure that a medication cart that stored drugs, was kept secured and locked.

On a specified date during the inspection, inspector #738 observed a medication cart in the hallway unlocked and unattended. RPN #128 was in a room across from the medication cart at that time. They returned to the medication cart and accessed the medication cart without needing to unlock it. Again, two minutes later, the medication cart was observed to be unlocked and unattended. RPN #128 was in a room across from the medication cart at that time. They returned to the medication cart and accessed the medication cart without needing to unlock it. Inspector #738 reported these incidents to DOC #105 approximately ten minutes later.

DOC #105 said they spoke to RPN #128 immediately after inspector #738 informed them that the medication cart was observed to be left unlocked and unattended. They said they told the staff member that they could not leave the medication cart unlocked. The staff member acknowledged they had left the medication cart unlocked at that time.

Ten minutes after inspector #155 spoke to DOC #105, inspector #155 observed a medication cart in the hallway unlocked and unattended. RPN #128 was in a resident room with their back to the door attending to a resident. They returned to the medication cart and accessed the medication cart without needing to unlock it.

Inspector #738 reported this incident again to DOC #105.

DOC #105 said they spoke to RPN #128 again when inspector #738 reported the medication cart was left unattended and unlocked. RPN #128 told DOC #105 that they needed to be given time to get the hang of it.

DOC #105 said staff were expected to lock the medication cart when they walked away from it or were not in visual sight of it.

The licensee failed to ensure that a medication cart that stored drugs, was kept secured and locked by RPN #128. [s. 129. (1) (a) (ii)]

2. On a second specified date of the inspection, the medication cart located by nursing station was left unlocked and unattended. Six residents were sitting in the immediate area.

Associate Director of Care #102 acknowledged that the medication cart was unlocked. [s. 129. (1) (a) (ii)]

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 the medication cart that stored medications was kept secure and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's shower had at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

The renovated resident shower area was observed to have one grab bar in the shower.

The DOOE #101 shared that they were not aware of the shower grab bar requirements.

The DOOE #101 observed the resident shower area and agreed that a grab bar was needed on the same wall as the faucet.

The licensee failed to ensure that the resident shower area had at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet. [s. 14.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to inform the Director of an incident no later than one business day after resident #014 was missing for less then three hours and returned to the home with no injury or adverse change in condition.

Progress notes for resident #014 identified an incident of elopement that occurred on a specified date. The progress notes stated that resident #014 was found by a staff member outside the home with another resident.

A review of the home's policy titled "Critical Incident Reporting", with attachment #XXXIII-D-10.30 (a) titled "Critical Reporting Events and Timelines" stated on page five that notification to the MOLTC no later than one business day for a resident who was missing for less then three hours and returned to the care community with no injury or adverse change in condition was to be initiated.

DOOE #101 stated that the home did not submit a CI to the MOLTC in relation to the incident of elopement.

The licensee failed to inform the Director of an incident no later than one business day after resident #014 was missing for less then three hours and returned to the home with no injury or adverse change in condition. [s. 107. (3) 1.]

Issued on this 27th day of January, 2020 (A2)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHARON PERRY (155) - (A2)
Inspection No. / No de l'inspection :	2019_781729_0018 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012214-19, 012218-19, 012220-19, 012225-19, 012227-19, 012231-19, 013566-19, 013567-19, 014068-19, 014957-19, 017629-19 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 27, 2020(A2)
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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Fleming

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

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

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: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0007, CO #015;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with s. 53(4)(a)(b) and (c) of O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that behavioural triggers for resident #074 and all other residents are identified;

b) Ensure that actions are taken to respond to the needs of resident #073, #074, #014 and #017 and any other resident exhibiting responsive behaviours, including assessments, reassessments and interventions and that the resident's response to interventions is documented;

c) That there is a process in place to monitor the documentation of residents daily to identify any new residents with responsive behaviours and ensure that a plan of care is developed for those new behaviours that includes any triggers, and interventions. Ensure that the triggers and interventions are communicated to all staff and the plan of care is implemented;

d) Develop an auditing tool that specifically evaluates residents experiencing ongoing responsive behaviours to ensure that referrals are completed, and the interventions to manage the responsive behaviours are current and the plan of care for residents is up to date; and

e) Ensure front line staff are involved in the planning, implementation and evaluation of responsive behaviour interventions for resident #073, #074 and all other residents.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #015 from inspection #2019_773155_0007 served on May 22, 2019, with a compliance date of June 21, 2019.

The licensee was ordered to be compliant with O.Reg 9/10, s. 53(4)(b) and (c).

The licensee was ordered to ensure that:
a) Ensure that the strategies that are developed to respond to the behaviours of resident #010, #014, #017 and any other residents with responsive behaviours are

implemented.
b) Ensure that actions are taken to respond to the needs of resident #014, #017, #030, #023, #038, #001 and any other resident exhibiting responsive behaviours, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.
c) Ensure that registered staff are provided training regarding the referral process to BSO, completion of behavioural assessments and implementation of interventions, and that there is a process developed and implemented to monitor and ensure that actions are taken by registered staff to respond to the needs of residents exhibiting responsive behaviours.

The licensee failed to complete steps a), b) and c) of CO #015.

1. The licensee failed to ensure that strategies were developed and implemented to respond to responsive behaviours, actions were taken to respond to the needs of the residents, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

A) A Critical Incident System (CI) report was submitted to the Ministry of Long Term Care (MOLTC) related to alleged physical abuse by resident #074 towards resident #073.

Resident #074 had a history of responsive behaviours directed towards co-residents. Resident #074's progress notes located in point click care (PCC) stated that on a specified date, resident #074 initiated an altercation with resident #073.

On three separate specified dates, progress note documentation stated resident #074 had verbal altercations with co-residents.

It was reported by a staff member that they witnessed resident #074 attempt to injure another resident. On another occasion resident #074 was witnessed in a physical altercation with another resident resulting in them being injured.

The Dementia Observation System (DOS) and thirty-minute monitoring form was reviewed for resident #074 from altercations with co-residents. The assessment and monitoring forms were not completed for multiple shifts after verbal and physical altercations occurred. There was no documented follow up of a review of the DOS

monitoring forms, assessments, and interventions implemented after the initial DOS monitoring tool was put in place.

PSW #120 and #133, RPN #124 and RN #134 stated that they referred to a resident's plan of care for direction related to behavioural interventions. Resident #074's plan of care did not identify any responsive behaviors, behavioural triggers, or interventions implemented to assess, monitor or evaluate resident #074 until several months after the resident was admitted to the home and had multiple altercations with co-residents.

PSW #133 shared that resident #074 preferred a quiet environment and found the noise of other residents difficult to ignore. They shared that they notified ADOC #102 and the BSO lead about the concerns with noise and the resident's behaviours in response, but nothing was done.

RPN #124 shared that resident #074 had specific triggers and that they had to intervene on more than one occasion when these triggers resulted in altercations between resident #074 and #073.

ADOC #102 stated that they were only aware of one specific responsive behaviour when the resident was admitted to the home.

At a care conference, resident #074 provided the team with one of their triggers. The plan of care was not updated to include the behavioural trigger identified at the care conference. ADOC #102 stated that prior to a specified date, they were not aware that resident #074's plan of care did not include responsive behaviours and the DOS charting and thirty-minute checks were incomplete.

The licensee failed to ensure that strategies were developed and implemented to respond to responsive behaviours, actions were taken to respond to the needs of resident #074, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

B) The licensee failed to take action to respond to the needs of resident #014 and #017 that included assessments and interventions and that the resident's responses to the interventions were documented.

A CI report submitted to the MOLTC alleged that on a specified date, resident #014 exhibited inappropriate behaviours towards resident #017.

Progress notes in PCC, stated that an incident occurred where resident #014 exhibited inappropriate behaviours towards another resident.

The home's policy titled "Sexual Expression and Intimacy" policy #VII-G-10.10 stated the nurse would, upon becoming aware of a resident request or observation of sexual expression by any resident, assess the situation. If unwanted sexual expressive behaviour occurred evidence of distress, injury or inappropriate for the surrounding environment, immediately intervene to ensure safety of residents and report to the Director of Care or nurse in charge.

Progress notes in PCC for resident #017, did not document that there had been an incident of alleged abuse between resident #014 and #017. There was no documentation of an assessment of resident #017 after the incident, nor was there any indication as to the resident's response to the incident.

There was no documentation in either the plan of care for resident #017 or resident #014 of any assessments or interventions the home put in place to keep resident #017 safe until four days after the incident occurred.

RPN #117 shared that no interventions were put into place as the incident was not documented and they did not know about it.

The licensee failed to take actions to respond to the needs of resident #014 and #017 that included assessments and interventions and that the resident's responses to the interventions were documented. [s. 53. (4) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm/risk of harm to the residents. The scope of the issue was a level 2 as it related to four of the nine residents reviewed. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of O.Reg 79/10 that included:

-Compliance Order (CO) #002 issued August 28, 2018, with a compliance due date of September 7, 2018 (2018_742527_0013).

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

-CO #015 issued May 22, 2019, with a compliance due date of June 21, 2019 (2019_773155_0007).

(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2020(A1)

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)

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0007, CO #013;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with s. 33(1) of O.Reg 79/10.

Specifically, the licensee must:
a) Ensure that residents #008, #027, #065, #071, and all other residents are bathed by the method of their choice at a minimum twice per week.

b) Develop and implement a daily tracking tool that documents the residents that were not bathed on their scheduled day, a plan to make up the missed bath/shower and to ensure the plan was implemented.

c) Ensure that an auditing process is implemented to ensure that residents are bathed at a minimum twice weekly by the method of their choice. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken with regards to the audit results.

d) Ensure that all nursing and personal care staff receive training on the use of the shower chair provided for showering residents.

Grounds / Motifs :

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

1. The licensee failed to comply with compliance order #014 from inspection #2019_773155_0007 issued May 22, 2019, with a compliance due date of July 15, 2019.

The licensee was ordered to be compliant with O.Reg 79/10, s. 33(1).

Specifically, the licensee must:
a) Ensure that residents #008, #015, #027 and all residents are provided bathing by the method of their choice at a minimum twice per week.
b) Ensure that there is a process in place that tracks the residents' bathing preference, by which method they were bathed and when they were bathed.
c) Ensure that an auditing process is developed and fully implemented to ensure that residents are being bathed by the method of their choice. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken with regards to the audit results.
d) Ensure that residents whose preferred method of bathing is a shower, that they are provided a shower in a functional and accessible shower area.

The licensee completed step b) of CO #013;

The Licensee failed to complete steps a), c) and d) of CO #013.

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #008's plan of care stated that their preference was a tub bath twice weekly.

Resident #008's point of care (POC) bathing documentation for one month showed that the resident was not given their choice of a tub bath on four occasions and was not given a bath at all on one occasion.

Resident #008's progress notes and alerts for the specified one month, did not contain any notes or alerts regarding why the resident was not bathed according to

their preference.

PSW #107 shared that resident #008 preferred to have a bath, however on a specified date, they gave resident #008 a shower.

RPN #117 shared there was no documentation as to why resident #008 was not given their choice of a tub bath on four occasions or why they missed a bath on one occasion and said there was no audit being done to ensure that residents were offered and received a minimum of twice weekly bathing according to their preference.

(155)

2. Resident #027's plan of care stated that their preference was a bath twice weekly, but to offer the resident a shower at that time because they had a medical condition.

Resident #027 shared that their bathing preference was a tub bath. They said they were never offered a shower but were given bed baths because of their medical condition.

Resident #027's POC documentation for bathing one month, showed they were given bed baths on eight occasions.

PSW #131 shared that resident #027 preferred to have a bath, however they were being given bed baths because they had a medical condition. They were not sure if the shower renovations were done, and had not had training on how to use the shower chair. (155)

3. Resident #071's plan of care stated their preference was a tub bath twice weekly.

Resident #071 told inspector #155 that it had been over a week since they had a bath. Instead, they were given a shower where they were placed in a chair suspended over the tub and sprayed.

Resident #071's POC documentation for bathing for one month showed that on one occasion they had a sponge bath at the sink, on four occasions they had a shower and on two occasions they had a tub bath.

RPN #117 said there was no documentation as to why resident #071 was being given showers instead of tub baths, and there was no documentation as to why resident #071 did not have a bath on two occasions within a two week timeframe. (155)

4. Resident #065 expressed concern to Inspector #738, that they had not received a bath in over a week. They preferred to have a tub bath twice a week, and had recently gone eight days without a bath.

Resident #065's POC documentation for bathing for one month showed resident #065 had a tub bath on five specified dates. On four specified dates resident #065 was given bed baths.

RPN #117 shared there was no documentation as to why resident #065 was given bed baths instead of tub baths on four specified dates.

The DOOE #101 and Quality Partner #115 shared that if a resident was not bathed according to their preference, or if the bathing activity did not occur, staff were to document this in a progress note, or they could create an alert.

Resident #008, #027, #071 and #065 were not bathed at a minimum of twice weekly according to their preference.

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it related to 4 out of 5 residents reviewed. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of O.Reg 79/10 that included:

-Compliance Order (CO) #005 issued August 29, 2018, with a compliance due date of September 28, 2018 (2018_742527_0012).
-CO #013 issued May 22, 2019, with a compliance due date of July 15, 2019, (2019_773155_0007).
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020(A1)

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)

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0007, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must be compliant with s. 15 (2)(a) of the LTCHA.

Specifically the licensee must:

a) Ensure that resident #078 and #079 and all other residents that require mobility aides are included in the home's "Monthly Equipment Cleaning Schedule";

b) Create a monthly audit of the equipment cleaning schedule to ensure that the items on the equipment cleaning schedule are cleaned. The audit should include any deficiencies, an action plan to address the deficiencies, and an evaluation to ensure the deficiencies were addressed. The audit should include the date it was completed, the person(s) responsible for the audit, and the person(s) responsible to ensure the follow up is completed.

c) Implement the action plan already developed by the home that included weekly audits and the person(s) responsible for completing the audits, to ensure that the walls, floors, baseboards, raised toilet seats, commodes, windows, window ledges, window screens, wall mounted fans, ceiling fans, ceiling vents, ceilings, vents, and furniture in the home are kept clean and sanitary. The action plan is to be monitored, analyzed and evaluated to ensure that the cleanliness of the home is sustained.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #005 from inspection #2019_773155_0007 issued on May 22, 2019, with a compliance due date of June 21, 2019.

The licensee was ordered to be compliant with s.15(2)(a) of the LTCHA.

Specifically the licensee was to prepare, submit and implement a plan for achieving compliance with LTCHA s.15(2)(a) to ensure the home, furnishings and equipment are kept clean and sanitary, specifically:

a) Review the schedule for the cleaning of resident #008 and other resident's wheelchairs and develop and implement an action plan to ensure that the resident's wheelchairs are cleaned as per the schedule. The action plan is to include how this

will be done and who is responsible to ensure it is implemented in the home.
b) Develop and implement an action plan, including weekly audits and the person(s) responsible for completing the audits, to ensure that the walls, floors, baseboards, raised toilet seats, commodes, windows, window ledges, window screens, wall mounted fans, ceiling fans, ceiling vents, ceilings, vents, and furniture in the home are kept clean and sanitary.
c) The plan shall include how any concerns or deficiencies identified in the audits will be monitored, analyzed, and evaluated to improve the cleanliness of the home.
The licensee has failed to ensure that the home, furnishings an equipment were kept clean and sanitary.

The licensee failed to complete steps a), b) and c) in CO #005.

The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A) Resident #078's wheelchair was observed for three consecutive days, with stains on the arm rests and cushion. Crumbs were also noted on the frame of the wheelchair.

Resident #079's wheelchair was observed for three consecutive days, with cobwebs noted in the right wheel.

Review of the Monthly Equipment Cleaning Schedule for the home areas showed that resident #078 was not listed on the schedule to have their wheelchair cleaned. Resident #079's wheelchair was initialed as being cleaned on a specified date. The Monthly Equipment Cleaning Schedule showed that staff initialed that resident #078's wheelchair was last cleaned two weeks prior to the inspected dates.

PSWs #120 and #127 said that all staff were responsible for wiping up or cleaning any spills or stains on resident wheelchairs or walkers when observed, but resident equipment had a deep clean once monthly on night shift as per the Monthly Equipment Cleaning Schedule.

Director of Resident Programs (DORP) #132 shared that all staff were responsible to clean the resident equipment at the time they saw spills or noticed that the equipment was dirty. DORP #132 stated that they were responsible for updating the

Monthly Equipment Cleaning Schedule. They reviewed the schedule and agreed that resident #078 was not on the Monthly Equipment Cleaning Schedule for a specified month.

DORP #132 observed resident #078 and #079's wheelchairs and acknowledged that they were not clean.

The licensee failed to ensure that resident #078 and #079 had their equipment, specifically wheelchairs, kept clean and sanitary.

B) For three consecutive dates during the inspection, the following was observed:
-Cobwebs, dead insects and dust were in the window panes of resident rooms, and the library;
-Dust build up in the ceiling vent in the library and in the hairdressing/shower room vents;
-Fan at the nursing station, and the standing fan the TV room were dusty;
-Cobwebs and dirt build up behind the library door, behind fire doors by a resident room, by fire doors near the physio room, in a resident room by the closet door, in the corner of the hallway by specified resident rooms, and in the corner of Lounge;
-Cobwebs and dirt build up in the large dining room by the two doors leading to the outside;
-Dead insects noted in the fluorescent light covers in the physio room and around the perimeter of the physio room;
-Floor in the physio room was dirty and had not been buffed; and
-Dead insects noted in the ladder laying in the exit doors.

Director of Dietary Services (DDS) #135 and DOQI #118 acknowledged the above deficiencies. DDS #135 shared they had not yet received a duster that was ordered to clean between the window panes. Review of records showed that a Long Reach Flexible Duster was ordered on a date during the inspection.

DOQI #118 shared that since August 2019, Room/Common Area Audits were being done with each room/area being audited once a month. They stated that when a housekeeping deficiency was noted an email would be sent to the DDS.

Review of the Room/Common Area Audit done on a specified date, showed a room was audited and it was noted there were spider-webs in the window. The audit

identified this concern was put into the Maintenance Care program for action.

The licensee failed to ensure that the home, furnishings, and equipment were kept clean and sanitary. [s. 15. (2) (a)]

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it related to all of the residents in the home. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of the LTCHA that included:

-Compliance Order (CO) #002 issued August 29, 2018, with a compliance due date of September 28, 2018 (2018_742527_0012).
-CO #005 issued May 22, 2019, with a compliance due date of July 4, 2019 (2019_773155_0007).

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2020(A2)

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)

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0007, CO #007;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.19(1) of the LTCHA.

Specifically, the licensee must:

a) Ensure that resident #073 and all other residents are protected from abuse by resident #074.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #007 from inspection #2019_773155_0007 served on May 22, 2019, with a compliance date of June 03, 2019.

Specifically, the licensee must:
a) Ensure that resident #037 is protected from abuse by residents #023 and #038.
b) Ensure that all residents are protected from neglect by staff.
c) Ensure that when there is a change in a resident's condition, staff provide the timely treatment, care, services and assistance required for the health, safety or well-being of the resident.

The licensee completed steps a), b), and c) of CO #007; however during this inspection, non-compliance was identified under the same section of the LTCHA s. 19(1).

1. The licensee failed to protect resident #073 from abuse by resident #074.

Physical abuse as defined by the regulations includes the use of physical force by a resident that causes physical injury to another resident.

A CI submitted to the MOLTC reported an allegation of physical abuse by resident #074 towards resident #073 that occurred on a specified date.

On a specified date, night shift staff and RN #134 observed resident #073 asleep with signs of several injuries.

ADOC #102 was notified and telephone support was provided. RN #134 stated they thought the injuries were self-inflicted, so no investigation was completed.

PSW #133 shared with inspector #729, that resident #077 told them they witnessed an altercation between resident #074 and #073. PSW #133 immediately reported the incident to RN #113.

PSW #133, #120 and RPN #124 said that resident #074 had a history of verbal and physical aggression towards resident #073 since resident #074's admission. There had been other altercations between resident #074 towards two other residents. The staff said that resident #074's behaviours were triggered by some of resident #073's actions and they had informed the ADOC of this, but nothing was done about it.

Resident #074's plan of care did not identify that the resident exhibited any responsive behaviours nor were there interventions in place despite documented incidents of verbal and physical aggression towards resident #073 and other residents, until three days prior to the physical altercation.

In an interview with resident #074 they stated that they knew what they had done was wrong and wished they had the common sense to leave people alone.

The licensee failed to protect resident #073 from physical abuse by resident #074. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to a resident. The scope of the issue was a level one as it related to one of the six

residents reviewed. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of the LTCHA that included:

-Compliance Order (CO) #001 issued August 28, 2018, with a compliance due date of September 7, 2018 (2018_742527_0013).
-CO #007 issued May 22, 2019, with a compliance due date of June 3, 2019 (2019_773155_0007).

(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020(A1)

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

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:

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

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

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

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 27th day of January, 2020 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SHARON PERRY (155) - (A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Central West Service Area Office