Ontario

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

Ministère des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

A 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:	Stacey Colameco
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:	2063412 Ontario Limited as General Partner of 2063412 Investment LP
LTC Home:	Creedan Valley Care Community
Name of Administrator:	Chantal Carriere

Background:

Creedan Valley Care Community ("the home") is a long-term care home in Creemore, Ontario within the North Simcoe Muskoka Local Health Integration Network (LHIN). The licensee, 2063412 Ontario Limited as General Partner of 2063412 Investment LP, ("the licensee") is licensed for 95 long-stay beds in the home.

On October 25, 2019, the Director under the *Long-Term Care Homes Act, 2007* (LTCHA) directed the local placement coordinator to cease admissions to the home on the belief that there was a risk of harm to the health or well-being of residents in the home or persons who might be admitted as residents. This decision was based on findings from previous inspections conducted at the home, including a follow-up inspection (2019-781729-0018) conducted on September 3-6, 9-13, 2019, which resulted in three findings of non-compliance being referred to the Director and six compliance orders issued to the licensee, four of which had been re-issued multiple times previously. The cease of admissions was effective October 25, 2019 and continues to remain in effect.

Since August 2018, the licensee has repeatedly failed to comply with numerous requirements under the LTCHA and Ontario Regulation 79/10 ("the Regulation"), including but not limited to:

- Developing and implementing strategies for responding to residents who exhibit responsive behaviours (Regulation, s. 53(4));
- Providing care to a resident as specified in their plan of care (LTCHA, s. 6(7));
- Bathing residents at a minimum twice per week by a method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition (Regulation, s. 33(1); and
- Ensuring that the home's staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the LTCHA and the Regulation (Regulation, s. 31(3)).

From inspections conducted between August 2018 to June 2020, repeated findings of non-compliance and multiple Compliance Orders have been issued for the same requirements under the LTCHA and Regulation. Despite these findings and orders, including the cease of admissions at the home and meetings with the licensee in October 2019, November 2019, December 2019, and July 2020, the licensee has failed to take the necessary actions to bring itself into compliance with the LTCHA and Regulation. Based on this, the licensee has demonstrated a lack of understanding of what is required to address non-compliance, sustain it, and operate the home in a manner that meets the requirements under the LTCHA and Regulation.

Subsection 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. Subsection 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.

The Director is issuing this Mandatory Management Order as the licensee not complied with several requirements under the LTCHA based on inspections conducted between August 2018 to June 2020. Further, the licensee has had an ongoing failure to comply with numerous requirements under the LTCHA and the Regulation. The licensee's ongoing and persistent non-compliance is demonstrated by the re-issuance of multiple Orders; the lack of understanding by the licensee of the compliance issues and the actions required to address and correct these serious issues; the risk of harm to residents in relation to the non-compliance found; and the ongoing instability in the home's senior leadership. The non-compliance and orders directly impact resident care and safety. All of these reasons provide the Director with reasonable grounds to believe that the licensee cannot properly manage the long-term care home. In addition, the Director has taken into account the factors under s. 299(1) of the Regulation in determining that this order is warranted.

Order:	

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP ("the licensee"), 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: 2063412 Ontario Limited as General Partner of 2063412 Investment LP ("the licensee") is ordered:

(a) to retain one or more persons, at your expense, described in paragraph (c) or (d) of this Order, to manage Creedan Valley Care Community located at 143 Mary Street, Creemore, Ontario ("the long-term care home");

(b) to submit to the Director **within 14 calendar days** of being served with this Order a proposed person(s) described in paragraph (a) to this Order;

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

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

(e) the person(s) described in paragraph (a) to this Order acceptable to the Director 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 LTCHA and Regulation;

(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 evidenced based practice and quality strategies;
4. the LTC home responds to issues identified during inspections; and
5. non-compliance in areas of actual harm or high risk of harm to residents and any other persons identified during inspections are rectified within the time frame required by the inspector.

(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 a written contract pursuant to section 110 of the LTCHA **within 14 calendar days** of receiving approval of the Director pursuant to paragraph (c) of this Order or the selection of a person(s) 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 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;

(h) to submit to the Director 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 as being in non-compliance **within 30 calendar days** of receiving approval of the Director

pursuant to paragraph (c) of this Order or the selection of a person pursuant to paragraph (d) of this Order;

(i) the person approved by the Director pursuant to paragraph (c) to this Order or selected by the Director 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; 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:

2063412 Ontario Limited as General Partner of 2063412 Investment LP (the "licensee") is licensed to operate a long-term care home known as Creedan Valley Care Community located at 143 Mary Street, Creemore, Ontario ("the LTC home").

The licensee's non-compliance

The licensee has not complied with several requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 (Regulation) under the LTCHA. This Order relies on all inspection reports, non-compliance findings and orders issued in the following inspections:

- 2018_742527_0012 - August 2018;
- 2018_742527_0013 - August 2018;
- 2019_773155_0007 - May 2019;
- 2019_545147_0007 - August 2019;
- 2019_781729_0018 - October 2019;
- 2020_773155_0001 - February 2020;
- 2020_781729_0006 - June 2020;
- 2020_781729_0005 - June 2020.

Below are key areas of non-compliance which the licensee has repeatedly fail to comply with between August 2018 to June 2020 and which pose a risk to the safety and well-being of residents.

Duty to protect re: Abuse and Neglect

Inspections have demonstrated that the licensee has failed to comply with s. 19(1) of the LTCHA, as it has not protected residents from abuse by anyone and that residents are not neglected by the licensee or staff.

- A compliance order was issued as a result of inspection 2018_742527_0013 conducted in June 2018. Over a 13-day period, a resident was sexually inappropriate with multiple residents that were not consenting to the behaviour. After the second incident, the home advised that they added an intervention to prevent further incidents, but inspectors found that the intervention was never implemented. Following the third incident and after the resident was assessed by an external consultant and community behavioral support team, several strategies were recommended and to be implemented by the home. Observations by inspectors identified that the strategies were not consistently being implemented, which put residents at continued risk of harm.

- During inspection 2019_773155_0007 conducted in March 2019, the licensee did not comply with the previous compliance order (from 2018_742527_0013) as further incidents of abuse and neglect were identified.

  - Specifically, a resident had a fall while trying to get up on their own. There were signs that the resident was trying to go to the washroom. The resident relied on their call bell for assistance to get up, but at the time, their call bell was not working. The call bell reportedly had not worked the day before the fall but no interventions were put in place to ensure that the resident could get the needed assistance while the call bell was not functioning.
  - A resident with a recent change in condition had 8 progress note entries over a 9-day period related to the change in status. There were no related assessments conducted by the home, vital sign monitoring and communication to the substitute decision-maker (SDM) over the 9-day period. There were no interventions to address the condition and on day 9, the resident was transferred to hospital where they died the following day. The SDM was not aware of a change in the resident's condition until they were notified of the resident being transferred to hospital.
  - A resident was identified as declining over a one-month period with decreasing consciousness, lethargy, reduced food and fluid intake, and reduced urine output. The home did not conduct nursing assessments or complete documentation of communication with the physician, or interventions put in place to address the resident's decline. The resident was transferred to the hospital where the resident was found to have a number of conditions which had not been addressed by the home. The resident was deemed palliative and transferred to hospice.
- During inspection 2019_781729_0018, the licensee failed to comply with a previous compliance order issued in September 2019 related to s. 19(1) of the LTCHA, related to a resident to resident altercation that resulted in injury. The resident who caused the injury

had a history of physical aggression towards the other resident who resided in the same room, as well as other residents. Staff had reported their concern about this resident's physical aggression to management of the home, but no interventions were put in place to prevent the physical aggression or to mitigate the risk of harm to other residents.

- During inspection 2019_781729_0020 conducted in October 2019, further evidence to support the compliance order issued in September 2019 regarding protecting residents from abuse was identified. A female resident reported to a staff member that a male staff member had come into their room when they were dressing and assaulted them. When the staff member reported the incident to registered staff, they said to wait until the following day to let management of the LTC home know. According to other staff in the home, this staff member had been inappropriate towards several staff and they had reported this to the management of the LTC home but nothing had been done.

Responsive Behaviours

The licensee has been issued multiple findings of non-compliance with s. 53(4) of the Regulation, as it has not ensured that strategies were developed and implemented to respond to residents demonstrating responsive behaviours.

- During inspection 2020_781729_0006 completed in February and March 2020, the licensee was found to be in non-compliance with s. 53(4) of the Regulation, as a resident who required pain medication prior to being provided care, as a strategy to manage their behaviours, was not provided the medication. During the inspection, the resident displayed the behaviours when being provided care.
- During inspection 2019_781729_0018 completed in September 2019, a finding under Regulation s. 53(4) was re-issued. This was related to a resident displaying responsive behaviours resulting in injury to another resident. Despite home staff indicating concerns with the resident's behaviour, interventions were not developed, the resident's behaviour not tracked and their care plan did not reflect the identified responsive behaviours. Further, during the same inspection, it was identified that a resident who demonstrated unwanted behaviour towards another resident did not have an assessment or interventions put in place to address this behaviour. Staff reported that interventions were not put into place as the incident was not documented and staff were unaware it had occurred.
- During a follow-up inspection completed in March 2019 (2019_773155_0007), the licensee was not compliant with s. 53(4) of the Regulation as the licensee did not ensure interventions for responsive behaviours were being implemented for multiple residents. This included one incident where a resident to resident altercation occurred as a result; an incident where a resident had a history of a specified behaviour towards another resident in which the Director of Care indicated that the home had not considered the behaviour inappropriate despite the co-resident reporting it bothersome; and identified multiple residents with responsive behaviours who did not have their Dementia Observation System (DOS) charting, BSO referrals, or responsive behaviour assessments completed.

- During inspection 2018_742527_0013, completed June 2018, Regulation s. 53(4) was re-issued related to staff providing direct one to one care to a resident who exhibited a specified behaviour and being unable to access the resident's plan of care. As a result, staff were unable implement the responsive behaviour plan of care and document the strategies implemented and the effectiveness of the responsive behaviour strategies.

Staffing

The licensee has not been consistently compliant with s. 8(3) of the LTCHA, as it has not ensured 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, except as provided for in the regulations. The licensee's non-compliance with s. 8(3) of the LTCHA has been issued during multiple inspections conducted since 2018 and there remains an outstanding compliance order related to s. 8(3) that the licensee has not yet complied with.

In addition, the licensee has not ensured compliance with the staffing-related requirements under s. 31(3) of the Regulation, as it has not ensured a staffing plan that provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the LTCHA and the Regulation.

- During inspection 2020_781729_0005, completed February and March 2020, concerns related to short staffing and use of agency staff in the home was reflected. Due to an inadequate staffing plan, the inspection identified concerns with meal assistance to residents, residents being served meals late, and in one instance, staff forgetting to provide a resident with their meal. During the inspection, Inspectors had to remind staff of residents who were not in the dining room. In the same inspection, inspectors observed a resident unable to provide their own personal care and crying while trying to dress themselves and another resident with matted, ungroomed hair. An inadequate staffing plan was also identified to have impacted PSW's ability to complete baths as required as well as residents not receiving the toileting routines required. One resident reported having frequent accidents due to the length of time required to wait for a staff member to be available to assist them to the toilet. Leadership reported that they had trained their staff on the homes contingency plan; however, staff reported that they had not received education on the plan.
- During inspection 2019_773155_0007 completed in March 2019, concerns related to the staffing mix were identified. Residents reported not receiving baths or not having certain areas of their body washed as the staff were completing the task quickly. Staff reported an inability to care for residents due to short staffing and a poor staffing mix, an inability to toilet residents as required, resulting in increased falls. Leaderships response in the home was that PSW's needed to work harder to complete the required tasks despite the inspection having identified that they were short an average of approximately 19-23 hours of PSW support in the home each day.

- During inspection 2018_742527_0012 completed in June of 2018, it was identified that bathing was impacted by PSW staffing shortages and the home not ensuring an adequate staffing plan and staffing mix that was consistent with residents' assessed care needs.

Qualifications of Staff, Ontario Regulation, s. 47(1)

- During inspection 2020_781729_0005, two Care Support Assistants (CSA) were working in the home. They reported that they were responsible for tasks that were within the meaning of "personal support services" as per s. 8(2) of the LTCHA. The leadership in the home reported that CSA's were not to be completing any hands-on care and reported that there had not been an audit. The Inspection determined that the CSA's were providing personal support services, including toileting, changing residents, assisting with dressing, and assisting with other areas of the residents' personal care and were doing so without the required qualifications as set out in s. 47(1) of the Regulation. A CSA told the Inspector that their job duties/description had been changed to be the same as a PSW.

Administrator Hours

- During inspection 2019_773155_0007 completed in March 2019, it was identified that the Administrator of the home was not working in the home the required number of hours as per Ontario Regulation 79/10, s 212(1).

Plan of Care

The licensee has not been compliant with s. 6(7) of the LTCHA, as inspectors have found that the licensee is not ensuring that residents are receiving the care as specified in their plans of care.

- During inspection 2020_781729_0005 conducted in February and March 2020, a compliance order related to s. 6(7) could not be complied. As the compliance order was being issued for the third time, a Director Referral was also initiated. This related to fall prevention interventions not being observed in place for multiple residents, all of which were high risk of falls and had several falls in the last 6-12 months. These interventions had been outlined in the individual resident's fall prevention plan of care but had not been implemented. Part of the order being followed up asked that an audit be conducted and documented in relation to residents' fall prevention interventions. At the time of the inspection, the home could not provide documentation of the requested audit being completed.
- During inspection 2019_545147_0007 completed in July 2019, the compliance order mentioned above was not complied with. Inspectors' observations showed that several fall prevention interventions for two residents, at high risk for falls, were not in place to mitigate their risk of further falls. In both situations, even after staff were notified and acknowledged that strategies specified in their plan of care were not in place, they did not intervene to address the risk. Two other residents, also at high risk of falls, were noted during

observations to not have their identified fall prevention interventions in place. A fifth resident who suffered an injury during a fall was to have a treatment on a specific day, as outlined in their plan of care. The resident did not receive the treatment as required, and only when identified by Inspectors several days later, was the treatment provided.

- During inspection 2019_773155_0007 completed in March 2019, a compliance order was issued. A resident at risk of falls, was observed multiple times without the falls interventions identified in their plan of care in place to mitigate the risk of the resident falling. A second resident, at high risk of falls, was observed in a risk position and calling for help. It was noted that several fall prevention interventions were not in place as outlined in the resident's plan of care.

Inspectors have also found non-compliance with s. 6(11)(b) of the LTCHA.

- During inspection 2019_545147_0007 completed in July 2019, the compliance order related to s. 6.(11) (b) could not be complied. Three residents, all at high risk of falls and with a history of frequent falls were reviewed during the inspection. It was noted that residents were reassessed after each of their falls, and despite current interventions not being effective, new approaches were not implemented to prevent further falls in the revision of the plan of care.
- During inspection 2019_773155_0007 completed in March 2019, a compliance order was issued. A resident was identified as having had 3 falls in a 4-week period. They sustained an injury at the time of the third fall. The resident was reassessed after each of their falls. Despite the assessment identifying that interventions had not been effective, new approaches were not implemented to prevent further falls in the revision of their plan of care. A second resident had 3 falls within two days: the last fall resulting in an injury. Despite assessments after each of the falls, no new approaches were added to the plan of care to prevent further falls.

Bathing

Multiple inspections have established that residents were not bathed at a minimum of twice a week by a method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, in accordance with s. 33(1) of the Regulation.

- Inspection 2019_781729_0018 conducted in September 2019 related to a complaint that residents were not being bathed at least twice a week. The inspection found that when short staffed, the home would pull their bathing shift to provide resident care. Often residents would not receive their scheduled bath or shower and could go up to 7-10 days without being bathed. Three of three residents reviewed did not receive their bath/shower at least twice weekly during the review period.

- During inspection 2019_773155_0007 conducted in July 2019, staff advised that when short 3 PSWs, the bath shift was pulled to assist with resident care. In this instance, they were told to provide a bed bath for residents. Inspectors reviewed a two-day period for both day and evening bath shifts and found that 77 per cent of residents were not being bathed according to their preference and in many cases were receiving a bed bath. One resident preferred a shower but because they were unable to walk, they could not access the home's shower. In this case, and for other residents not able to walk, their shower involved being suspended in a sling above the bath and sprayed with the tub hose. There were also concerns brought forward about privacy, as they had two tubs located in the same room and often residents were being bathed side by side with only a thin curtain between them. Three of three residents reviewed were not being bathed at least twice a week according to their preference.
- During inspection 2019_781729_0018 conducted September 2019, evidence supported ongoing problems where residents were not being bathed at least twice a week according to their preference. One resident that preferred a bath was given a shower whereby they were suspended above the bath and sprayed. The resident told inspectors this made them shake as they were scared. Another resident that preferred a tub bath went eight days without being bathed and during the same month they received four bed baths.
- During inspection 2020_781729_0005 conducted in February and March 2020, one resident who preferred a tub bath was told that they could not always have a tub bath because it was booked. Seven of the nine times they were bathed, they were given a shower instead of their preferred bath. Another resident preferred a tub bath, but because of an identified skin concern was to have a shower, but was not given either. Instead, they were provided a bed bath.

Infection Prevention and Control

The licensee has not complied with s. 229(4) of the Regulation as it has not ensured that all staff participated in the implementation of the LTC home's infection prevention and control program.

- During inspection 2020_781729_0005 conducted February and March 2020, the home was in an enteric outbreak. Inspectors observed that the home was not complying with its infection program and control program, as inspectors found documentation that several residents exhibiting signs and symptoms of infection were not on the line listing and isolation precautions were not being followed as required by the program. In one case the resident attended the dining room, and the following day two more residents were symptomatic. In another situation a resident was removed from the line listing and isolation precautions despite continuing to exhibit symptoms consistent with the case definition.
- A memo sent to all the LTC homes by the Assistant Deputy Minister of Long-Term Care Operations on March 11, 2020, related to COVID-19, stated that all homes were to actively screen staff and visitors and to have an active screener at the home's entrance to conduct the screening during business hours. During observations by the inspection team from

March 11 to March 13, 2020, the home did not implement active screening by a screener at the home's front entrance or any other entrances into the home.

Licensee's inability to achieve and sustain compliance

A Director's Order was issued October 25, 2019 ordering the licensee to dedicate internal resources with extensive experience in managing/operating a LTCH to be on-site at the home on a full-time basis with the sole responsibility and job function to assist the home.

On October 25, 2019, as part of the Director's Order, the Director also requested the LTCH to submit an action plan with a primary focus of implementing actions at the staff level in order to achieve and sustain compliance. The action plan was to be submitted to the Director by November 15, 2019 for approval.

On November 26, 2019, a face to face meeting was held with the licensee, the home's leadership team, a Senior Manager (Ministry) and members of the Central West Service Area Office (Ministry) to review the action plan submitted by the home at the Director's request. It was identified during this meeting that the licensee had not complied with the Director's Order from October 25, 2019 with respect to having a dedicated full-time resource in the home with extensive experience in operating or managing LTC homes, whose sole responsibility and job function was to assist the home in achieving and sustaining compliance. At the time of this meeting, the home did not have a dedicated full-time resource onsite at the home as required by the Director's Order. Follow-up by the Director led to the appointment of a full-time resource that commenced work in the home on December 4, 2019, approximately six weeks after the Director's Order was issued. The action plan reviewed at this meeting did not include a specific plan to comply with the outstanding orders. It was very general. The home was asked to resubmit an action plan by December 6, 2020. Following this meeting, the Ministry was contacted by representatives of the licensee and home requesting clarification in relation to outstanding compliance orders and Director referrals as they were having difficulty determining the applicable orders. Despite reviewing the LTC home's history with the licensee, the home and the licensee reported being confused. A call was held with the home's leadership and a representative from the licensee on December 4, 2019 to review all outstanding orders and Director referrals. In addition, some explanation was provided in relation to identifying and tracking orders. A revised action plan was submitted on December 6, 2020.

On January 13, 2020, a face to face meeting was held with the Licensee, the home's leadership and members of the Central West Service Area Office to review the home's revised action plan, submitted December 6, 2019, and progress towards achieving compliance. During the process of reviewing each order, it was identified that the specifics of the orders the home had outlined were not correct. It was determined that the specifics of five out of eight orders had been copied from old reports and they were not the current orders. As a result, the action plans developed by the Licensee were not relevant to the most recent compliance issues and residents involved. In

addition, one of the orders had not been captured on the plan and thus there were no actions identified to address this order.

The Ministry has held multiple meetings with representatives of the LTC home and the Licensee to discuss the compliance concerns at the home and to assist the licensee in developing an action plan that can be implemented to bring the licensee into compliance. Despite these meetings, the Licensee continues to struggle with understanding and tracking their outstanding orders and Director referrals and taking the appropriate actions needed to achieve compliance, including devising the necessary plans. The lack of leadership, action and urgency demonstrated by the licensee supports that the licensee cannot manage the home.

Management Instability and Concerns

The LTC home has been experiencing management instability which has contributed to its lack of action and ability to address the compliance issues at the home, including operating the home in a manner consistent with the requirements of the LTCHA and Regulation.

The Administrator at the home has been there since August 20, 2019 and the Director of Care (DOC) has been at the home since September 3, 2019. Prior to the DOC commencing work at the LTC home, they did not have any previous experience working as a DOC. The LTC home reported on July 23, 2020, that the DOC was currently off. The home pulled their full-time day RN to cover the DOC role and an RPN has assumed the full-time day RN position. As of July 23, 2020, the ADOC position remains vacant.

As noted, a Director's Order was issued October 25, 2019 ordering the licensee to dedicate internal resources with extensive experience in managing/operating a LTCH to be on-site at the home on a full-time basis with the sole responsibility and job function to assist the home. The internal dedicated resources have changed within the home on at least two separate occasions and staff reported that during COVID-19 there was not a dedicated corporate resource on-site in the home on a full-time basis.

Individuals in the key leadership roles within the home lack experience and despite corporate support, meetings and frequent communication with Central West Service Area Office managers, the licensee continues to struggle to understand inspection reports, identified areas of non-compliance and the specifics of the orders, including steps needed to address these concerns. On more than one occasion, the Ministry has provided a written summary outlining what compliance orders and Director referrals were outstanding in the home. These summaries were either requested or necessary in order to assist the home with their understanding of the current outstanding compliance concerns so they could develop accurate action plans to address the identified resident care and safety concerns. Licensees should be aware of outstanding compliance issues at their homes at all times, including all orders and director referrals.

The LTC home has had a history of frequent leadership turnover dating back to 2018. Since that time, they have had 3 permanent Directors of Care and 3 Administrators in addition to several that acted on an interim basis to cover when the positions were vacant. These vacancies and turnover represent instability within the home at the management level and contribute to the inability for the senior leadership to provide direction and expertise to effectively understand the compliance issues and manage the home in accordance with the requirements under the LTCHA and the Regulation. The home, despite internal supports from their corporation, have repeatedly failed to create a culture of accountability, improvement, and quality of care for residents in the home.

This Order is being issued based on the licensee's ongoing inability to maintain effective leadership in the home that is necessary to execute change and achieve compliance which has put residents' health, safety and quality of life at risk in the LTC home for over 2 years. Since August 2018 to June 2020, the home has had a total of 10 inspections resulting in 80 written notifications, 31 voluntary plans of correction, 42 compliance orders, 8 director referrals and 1 Director's order.

Based on the licensee's repeated and ongoing failure to ensure the LTC home complies with the LTCHA and the Regulation, the instability of the long-term care home's management and inability to take appropriate actions, the licensee's failure to comply with inspector and Director's Orders since 2018, I have reasonable grounds to believe that the licensee cannot properly manage the LTC home.

Furthermore, the decision to issue this Director's Order is based on the scope and severity of non-compliance, and the LTC home's compliance history over the past 36 months. The scope of non-compliance is identified as widespread in the LTC home and represents systemic failure that affects or has the potential to negatively affect many LTC home's residents. The severity of the non-compliance is determined to be actual harm or risk of actual harm. As noted in this Order, the licensee has a history of repeated non-compliance with several requirements under the LTCHA and Regulation. The licensee has a level 5 compliance history for this home, as there have been compliance orders re-issued for non-compliance related to the same requirements under the LTCHA and/or Regulation and the licensee being issued 4 or more compliance orders.

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:

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

Ministère des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Health Services Appeal and Review Board and the **Director**

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

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 07 day of August , 2020	
Signature of Director:	
Name of Director:	Stacey Colameco