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
Oct 23, 2020	2020_781729_0005 (A2)	012219-19, 012221-19, 012224-19, 016339-19, 016340-19, 016341-19, 019704-19, 019705-19, 019706-19, 000524-20, 001994-20, 002443-20	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 KIM BYBERG (729) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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This report has been revised to reflect changes for a request of extension for outstanding compliance orders. The Follow-up inspection #2020_781729_0005 was completed on February 24-28, March 2-7, 9-13, 2020.

A copy of the revised report is attached.

Issued on this 23rd day of October, 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

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

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

Amended by KIM BYBERG (729) - (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): February 24, 25, 26, 27, 28, March 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 2020.

The following intakes were completed within the follow up inspection:

-Log #012219-19, follow-up to compliance order (CO) #006 from inspection #2019_773155_0007 related to housekeeping and maintenance;

-Log #012221-19, follow-up to CO #008 from inspection #2019_773155_0007 related to training and orientation;

-Log #012224-19, follow-up to CO #012 from inspection #2019_773155_0007 related to sufficient staffing;

-Log #016339-19, follow-up to CO #001 from inspection #2019_545147_0007 related to skin and wound care;

-Log #016340-19, follow-up to CO #002 from inspection #2019_545147_0007 related to care planning for fall prevention;

-Log #016341-19, follow-up to CO #003 from inspection #2019_545147_0007 related to care planning for fall prevention;

-Log #019704-19, follow-up to CO #004 from inspection #2019_781729_0018 related to prevention of abuse and neglect of residents;

-Log #019705-19, follow-up to CO #002 from inspection #2019_781729_0018 related to residents bathing;

-Log #019706-19, follow-up to CO #003 from inspection #2019_781729_0018 related to housekeeping and maintenance;

-Log #019707-19, follow-up to CO #001 from inspection #2019_781729_0018 related to responsive behaviours;

-Log #000524-20, related to qualification of personal support workers and sufficient staffing;

-Log #001994-20, CI #2633-000004-20 related to medication management;

-Log #002443-20, CI #2633-000011-20 related to personal support services and skin and wound care for residents.

This inspection was completed in conjunction with the Director Order Follow up Inspection #2020_781729_0006.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 53, was identified in this inspection and has been issued in Inspection Report #2020_781729_0006 dated June 8, 2020 which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with with the Director of Operational Effectiveness (DOOE), Director of Quality and Informatics (DOQI), Executive Director (ED), Director of Care (DOC), Interim Assistant Director of Care (IADOC), RAI Coordinator (RAI), Scheduling Coordinator, Office Manager, Clinical Care Partner, Sienna Menu Planner, Director of Programs and Admissions (DOPA), Director of Environmental and Food Services (DOEF), Resident Service Coordinator (RSC), Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), Care Support Assistant (CSA), Resident Service Coordinator (RSC), Nexium Agency PSW, Gifted Hands 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.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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

- **8 WN(s)**
- **3 VPC(s)**
- **6 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
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #006	2019_773155_0007	729
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #003	2019_781729_0018	155
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #004	2019_781729_0018	729
O.Reg 79/10 s. 50. (2)	CO #001	2019_545147_0007	738
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #003	2019_545147_0007	743

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #004, #019 and #021 as specified in the plan.

A) Resident #021 was at moderate risk for falls with multiple documented falls since their admission.

A post fall assessment documented they were found sitting on the floor and could not reach the call bell.

Resident #021's plan of care stated to ensure their call bell was within reach. After their fall on a specified date, the plan of care was updated to include fall interventions to improve safety with transfers.

One month later, it was observed that resident #021’s call bell was not within reach.

According to resident #021, where they sit during the day they are not able to reach the call bell. They also confirmed that after a recent room change, the new fall interventions were not re-installed.

Staff member #144 was unsure what the fall prevention interventions were for resident #021. Staff member #144 confirmed that the call bell could not be reached at the location that the resident usually sits at during the day. They also said that occasionally resident #021 was unable to move from their chair and would throw an identified object out the door to indicate assistance was required. Staff member #144 said this was not a safe method of calling for assistance.

B) Resident #019 was at moderate risk for falls, with a history of multiple falls in 2019. Fall prevention interventions in their plan of care included to ensure that when resident #019 was in bed, specific fall injury prevention interventions were to be in place.

On a specified date, resident #019 was observed sleeping in their bed without their safety interventions in place. Staff member #154 said they had just assisted resident #019 to bed and acknowledged that they forgot to ensure the safety intervention was in place.

IADOC #141 said staff did not follow the resident’s plan of care on two specified dates and they also observed the same issue.

C) Resident #004 was at moderate risk for falls. The plan of care indicated that

resident #004 was to have a wheel chair alarm on their chair.

On a specified date, resident #004 was observed with their wheelchair clip alarm attached to their chair and not to them specifically. The clip alarm remained unclipped.

IADOC #141 confirmed that resident #004 was to have a clip alarm and the alarm was to be be clipped to them whenever they were in their wheelchair.

D) Compliance order #002 from inspection #2019_545147_0007 required the home to complete an audit to ensure the plan of care for residents at moderate or high risk for falls was provided to residents as specified in the plan of care. IADOC #141 and CP #142, said they were unable to provide documentation for the audit as the home did not have the information that was being requested as specified in the compliance order.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #021, #019 and #004 as specified in their plan.

The licensee also failed to develop an audit system as ordered in the home's compliance order to ensure that the plan of care for residents at moderate to high risk for falls was provided to the residents as specified in their plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #025 and #028 as specified in the plan.

A) Resident #025’s current care plan and annual nutritional assessment completed on a specified date, stated that resident #025 was to receive high protein (HP) drink, two servings at meals to promote weight maintenance/gain.

On a specified date, during breakfast resident #025 was observed by inspector #729. Resident #025 was not offered any HP drink during the breakfast meal. However it was documented that they had a serving.

On a specified date, during lunch resident #025 was observed by inspector #729. Resident #025 was not offered any HP drink during the lunch meal. However, their intake was documented as one serving. fluid.

B) Resident #028's dietary assessment note in PCC on a specified date, stated that resident #028 was to receive HP milk two servings at meals to promote weight maintenance.

On a specified date, during lunch resident #028 was observed by inspector #155. Resident #028 was not offered any HP drink during the lunch meal.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #025 and #028. [s. 6. (7)]

3. The licensee has failed to ensure that documentation into resident #003 and #023's electronic treatment administration record (eTAR) was documented as set out in the plan of care.

A) Resident #003 had multiple areas of impaired skin integrity that had prescribed treatments ordered and entered into the eTAR that required the nursing staff to complete and document the treatment.

Resident #003's eTAR for a specified month, showed that resident had skin impairment and to administer a prescribed treatment one time per day. The eTAR showed that on six days of the month, there was no documentation that the treatment was completed.

Resident #003 had a second skin impairment with a prescribed treatment to be completed every two days. The eTAR for the specified month showed three times in the the month that there was no documentation that the treatment was completed.

Resident #003 had a third area of skin impairment and a physician order was to be completed twice per day The eTAR for a specified month showed six days in the month the prescribed treatment was not completed.

A review of resident #003's progress notes did not indicate that any treatments were completed on the specified dates.

Staff member #107 shared that all treatments that were completed would be documented in the eTAR, and if it was not signed in the eTAR there should be a progress note of the treatment provided.

B) Staff members #109, #133 and IADOC #141 stated that treatments for altered skin integrity were found and documented in a resident's eTAR.

Resident #023's eTAR showed they had areas of altered skin integrity that required a treatment every other day. There was no documentation on the eTAR or progress notes to show the treatment had been provided for four days in the specified month for one area of impairment and no documentation for three days on the second area of altered skin integrity.

Staff members #109 and #133 reviewed resident #023's February 2020 eTAR with Inspector #738. They acknowledged there was no documentation to show the treatments identified above had been provided.

IADOC #141 believed that staff were completing resident #023's treatments as required because their altered skin integrity was improving but they not document it.

The licensee has failed to ensure that documentation into resident #003 and #023's electronic treatment administration record (eTAR) was documented as set out in the plan of care. [s. 6. (9) 1.]

4. The licensee failed to ensure that the provision of the care set out in the plan of care was documented for resident #028.

On a specified date, resident #028 was observed by inspector #155 during lunch meal. Resident #028 was assisted by staff member #153. Resident #028 took 0.75 servings of soup, two servings of orange liquid and fifty percent of their main course.

Review of resident #028's food and fluid documentation done in POC for the specified date, showed that there was no documentation done for the breakfast or lunch meals.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 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# 001

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

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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
7. Fire prevention and safety.
9. Infection prevention and control.

Director of Programs and Admissions (DOPA) #119 said staff were required to complete Relias training, and in-person fire prevention and safety training prior to performing their duties. They said this training included education on the areas mentioned above.

A) Records showed that staff member #115 was hired at the home on a specified

date, and worked at the home three days later. They did not receive training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents or fire prevention and safety training prior to performing their duties.

B) Records showed that staff member #116 was hired at the home on a specified date, and worked at the home two months later. They did not receive training on the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, fire prevention and safety, and infection prevention and control prior to performing their duties.

C) Records showed that staff member #113 and #114 were hired at the home on a specified date, and worked at the home three weeks later. They did not receive training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their duties.

D) Records showed that DOC #103 was hired at the home on September 3, 2020. They did not receive training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their duties.

DOPA #119 confirmed staff members #115, #116, #113, #114, and DOC #103 did not receive training in the above mentioned areas prior to performing their duties.

DOPA #119 and Director of Operational Effectiveness (DOOE) #102 said an error had occurred and the home's policy to promote zero tolerance of abuse and neglect was not programmed in Relias to be delivered annually. They said this error led to the above mentioned staff not receiving abuse and neglect training prior to performing their duties.

The licensee has failed to ensure that staff members #115, #116, #113, #114, and DOC #103 received training in the areas mentioned below prior to performing their responsibilities:

1. The Residents' Bill of Rights.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
7. Fire prevention and safety.
9. Infection prevention and control. [s. 76. (2)]

Additional Required Actions:

CO # - 002 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# 002

DR # 001 – 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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

DOC #103 and ED #101 both shared that the PSW staffing plan was:
Days - 10 PSWs working 0600-1400 hours;
Evenings - 10 PSWs working 1400-2200 hours; and
Nights - 2 PSWs working 2200-0600 and 2 PSWs working 2300-0700 hours.

ED #101 shared that when Care Service Assistants (CSA) work they are not counted as PSW's, and that they were in their own category. They also stated that the staffing complement had not changed even with the twelve empty beds so that resident care should be seamless.

Scheduling Coordinator #112 provided the reconciled Daily Nursing Rosters for the period of February 1, 2020, to March 6, 2020. Review of the reconciled Daily Nursing Rosters for the period of February 1 to March 6, 2020 was done.

For the period of February 1 to February 14, the home had 180 vacant PSW hours.
For the period of February 15 to February 28, the home had 195 vacant PSW hours.
For the period of February 29 to March 6, the home had 150 vacant PSW hours.

The staffing shortages impacted resident care in multiple areas:

A) Assistance at meals:
The posted meal times stated that breakfast was at 0830 hours, lunch at 1230 hours and supper at 1700 hours.

i) On a specified date, there were 7 PSW's working during the day shift and the usual staffing is 10. Resident #020 and resident #042 were observed in the large dining room to be served their soup at 1302 hours.
-Resident #013 was not offered any soup and was given their main course at 1302 hours.
-Lunch finished at 1358 hours, one hour and 28 minutes after the start of meal service.
-There were nine residents on enteric isolation

ii) On a specified date, resident #020 was served breakfast at 0913 hours.
-Breakfast finished at 0945 hours.
-Lunch finished at 1400 hours.
-There were nine residents on enteric isolation.

iii) On a specified date, resident #020 was saying that they were hungry. Soup was served to resident #020 at 1315.
-Resident #044 who required to be fed by staff received this help at 1315 hours.
-Resident #013 was not offered soup, was given the main course and fed by staff.

-Resident #021 shared that breakfast and lunch were for the most part always one-half hour late. They shared breakfast was to be at 0830 and it did not usually start until 0900 hours or later, and lunch was to be at 1230 hours and it did not usually start until 1300 hours. They expressed that during the outbreak that coffee club was cancelled, and when they were use to getting a coffee around 0700 hours, they expressed that having to wait until 0900 hours or later for a coffee was a long time.

iv) On a specified date, breakfast finished at 0940 hours and the tea cart started to be served at 1002 hours.
-At lunch resident #029 and #044 were served their soup at 1308 hours.
-Residents #017, #020 and #025 were served their fluids at 1311 hours.
-Residents #017 and #025 who required to be fed by staff, received assistance with their lunch at 1324 hours, 54 minutes after the start of meal service.
-There were four residents in enteric isolation.

v) On a specified date, resident #028 who was in enteric isolation was not fed their breakfast tray. Staff member #134 shared that they had forgot to feed resident #028 their breakfast tray.

vi) On a specified date, breakfast started at 0900 hours. At 0904 hours, RAI-Coordinator #104 served resident #045 their breakfast and sat to feed them at table one. No other residents where noted at table one. When inspector #155 inquired as to where resident #046 was, staff member #124 went and got resident #046 from their room. RAI-Coordinator #104 then got resident #046 their breakfast and started to feed them.

B) Personal Care

i) On a specified date, resident #032 was given a basin of water and left with their clothes beside them on the bed at 0850 hours. At 0908 hours resident #032 remained sitting on side of bed in front of basin crying at times while trying to dress. Resident #032 was observed at 1125 hours and 1455 hours and did not have socks on.

ii) On a specified date, there were 9 PSWs working during the day shift. Resident #017 was removed from isolation on this day and PSW staffing on one specific unit was all agency staff. Resident #017 was observed to have matted hair. DOOE #102 agreed that resident #017's hair was not clean and groomed and later shared that they had the staff take resident #017 to the spa room to have their hair washed.
-There were 10 residents on enteric isolation

C) Bathing

i) Staff member #124 shared that resident #004 was not bathed on the day shift on a specified date, as per the bath schedule due to time constraints as there

were only two PSW's on the unit during day shift.

D) Toileting Routines

i) Resident #043 shared that they often had to wait for 20 minutes after they rang their call bell after meals to get assistance to go to the bathroom. They shared that they often had an accident by the time the staff were able to get to them to assist them to the bathroom.

ii) On a specified date, resident #006 rang their call bell at 1322 hours asking to go to the bathroom and then to bed. Staff member #133 responded at 1325 hours, and said they would get some help. At 1335 hours, resident #006 rang their call bell asking to go to the bathroom and bed. At 1340 hours, staff member #133 answered the bell and said they would get some help. At 1343 hours, resident #006 rang their call bell and staff responded at 1345 hours helping resident #006 to the bathroom and then to bed.
-There were six residents in enteric isolation.

A number of staff members expressed that when they do not have their full complement of staff on their shift that managers do not come and assist in the dining rooms. They shared that if they do express that they do not have their full complement of staff and ask for help, they are told that they are twelve beds down so they should not have a problem getting their work done.

During interview with ED #101, they shared that they had one part time night RN position, one full time RPN position, and twenty-two vacant PSW positions. Of the twenty-two vacant PSW positions, four were for full time days, three were for full time evenings, four were for part time days, seven were for part time evenings and 4 were for part time nights. They shared that they enter the postings in Ultipro and that puts them on Sienna’s web site and also on the Indeed website.

Review of Sienna’s web site and Indeed web site was done. There were no postings noted for the RN or any PSW positions.

ED #101 shared that they had been doing the bi-weekly reviews of the staffing plan.

A Review of the ED's review of the staffing plan was done. Analysis and evaluation of the staffing plan dated January 31, 2020, stated that the bathing

schedule was reviewed and updated to reflect staffing levels February 20, 2020. Staffing plan revised January 23, 2020, by home area. Quality indicators reviewed and falls reviewed by home area. Trillium Way was noted to have the highest falls rate with an average of eight falls, Poppy Lane with an average of five falls and Lilly Way and average of three to five falls. "We continue to have full compliment of staff for each home area."

The analysis and evaluation of staffing plan dated February 14, 2020, stated that review of the staffing for the month of January 2020, was done. The home continued to complete interviews for ADOC, ESM, RN, RPN and PSWs. The home continued to bring in agency on an average of nine to fourteen PSW agency staff working every day. They continued to have town hall meetings for all shifts during the month of January 2020.

The analysis and evaluation of the staffing plan dated March 2, 2020, stated the home continued to monitor daily missed shifts. Review of staffing for the month of February 2020, was done and noted that RN missed shifts were seven and these were covered by the DOC, RPN missed shifts were three and these were covered by the RAI/ADOC, and PSW missed shifts were twelve on days, four on evenings, four on nights and Care Support Assistant had one missed shift. On average the home uses nine to fifteen agency PSWs, RPNs and RN in a given 24-hour period. The resident census was eighty-three and the complement of staff has not changed.

Review of the reconciled Daily Nursing Rosters for the period of February 1 to February 29, 2020, for PSW missed shifts was done. The review showed there were:
-32.5 missed shifts on days;
-18 missed shifts on evenings;
-4 on nights.

The analysis and evaluation of the staffing plan dated March 2, 2020, also stated that the ESM position remained vacant and the ADOC, RPN and PSW was hired.

ED #101 shared that the DOC had educated the staff on the back-up staffing plan/contingency plan and that it was available in the resource binder on the nursing units. When asked what the minimum number of staff that were allowed on each shift ED #101 shared that if they were down to half the staff on days and evenings it would be unreasonable to ask their staff to do that, and at that point

managers would come in to help. On the night shift they would have a manager come in only if they had 1 RN and 2 PSW's in total for 3 homes areas.

DOC #103 shared that the back-up staffing plan/contingency plan had evolved over time and it was placed in the staff phone number book or resource binder and that it was still being rolled out. They stated that they wanted staff to give feedback on it. When asked what the minimum number of staff that were allowed on each shift before managers would come in to work, DOC #103 shared that on days or evenings if they were 3 or 4 PSW's down, than the call goes to the manager on call. If they were not able to get anyone to come in, then they would get activity staff to pitch in. If they had more than 3 PSW's down, then the nursing managers needed to be in the dining room helping.

A review of the back-up staffing plan/contingency plan identified the plan/strategy and the duties that must be done for staff vacancies. There was nothing in the staffing plan/contingency plan as to who was to assist or come in to work if the home was 4 or 5 PSW's down.

Staff member #133 was shown the back-up staffing/contingency plan that was placed in the staff phone number book or resource binder. They shared that they had never seen the document and had not been educated on it. Staff member #106 shared that the back-up staffing/contingency plan was put into the resource binder the week of March 2, 2020. They shared that they had no education or instruction about the plan.

The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs. [s. 31. (3)]

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 # 003 – 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 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 resident #004, #008 and #014 were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) Resident #004's care plan stated that their preference was a tub bath twice weekly, but due to impaired skin integrity, resident #004 was to receive a shower twice weekly.

Review of the bath schedule showed that resident #004 was to have a bath on specific days.

Resident #004's POC bathing documentation for one month, showed that resident #004 had a tub bath on specified dates. There was no documentation in resident #004's progress notes as to why resident #004 was given a tub bath and not a shower as per the care plan.

Staff member #123 and #124 shared that they refer to the bath schedule, and care plan to find out the bathing preference for residents. Review of the bath schedule and care plan was done with staff member #119, and they shared that the bath schedule was not updated to reflect that resident #004 was to have a shower, and that resident #004 should have had showers and not tub baths. Staff members #123, #124 and #119 all shared that when a resident was not given their bathing preference, the registered staff were to be notified, and enter a progress note, or if comfortable, the staff member could enter the progress note themselves as to why the resident was not given their bathing preference.

Bathing audits were completed for resident #004 but they did not capture that resident #004 was not getting their shower as per the plan of care as the bath schedule indicated that resident #004 was to get a tub bath.

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

Review of the bath schedule for showed that resident #008 was to have a tub bath on Thursdays and Sundays.

Resident #008's POC bathing documentation for one month, showed that resident #008 had a shower on on two specified dates. There was no documentation in resident #008's progress notes as to why resident #008 was given a shower and not a tub bath as per the care plan.

Staff member #123 and #124 shared that they refer to the bath schedule and care plan to find out the bathing preference for residents.

Review of the bath schedule and care plan was done with staff members #123 and #124 and they shared that resident #008's bathing preference was a tub bath. Staff members #123, #124 and #119 all shared that when a resident was not given their bathing preference the registered staff were to be notified and enter a progress note, or if comfortable the staff member could enter the progress note themselves as to why the resident was not given their bathing preference.

Staff member #119 shared that resident #008 did not get their bathing preference of a tub bath on the specified dates and there was no progress notes made as to why they were given a shower.

Bathing audits were completed for resident #008 which showed they had a shower on a specified date, as they were on enteric isolation and there was no action/follow up noted. The bathing audit on a specified date, showed that resident #008 got a shower and there was no action/follow up noted. Staff member #119 shared that follow up with staff member #126 was done and that staff member #126 shared that a shower was given because the tub room was busy.

C) Resident #014 shared that their bathing preference was a tub bath twice weekly. When asked why they were receiving showers they shared that staff told them that the tub room was all booked up.

Staff member #119 and #123 shared that resident #014 could express what their bathing preference was and if they changed their preference from what the care plan or bath schedule indicated, staff were to offer resident #014 what they requested at the time of offer.

Review of the bath schedule showed that resident #014 was to have a shower on Tuesdays and Saturdays. Review of resident #014's care plan stated that their preference was a shower.

Resident #014's POC bathing documentation for one month, showed that resident #014 had a tub bath on two dates. There was no documentation in resident #014's progress notes as to why resident #014 was given a tub bath instead of a shower. On eight specified dates, resident #014 was given a shower however they stated their preference is a tub bath.

Staff member #141 shared that resident #014 told them that they were given a shower by staff because it was more convenient for the staff.

The licensee failed to ensure that resident #004, #008 and #014 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. [s. 33. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber for resident #001 and resident #012.

A) On a specified date, a Critical Incident (CI) was reported to the Ministry of Long-Term Care (MLTC) regarding the improper/incompetent treatment of a resident that resulted in harm or risk of harm to the resident. The report stated that a medication order was received for resident #001, but that it was not transcribed. The resident was sent to hospital and admitted.

Staff member #107 confirmed that they did not transcribe or process the telephone order for resident #001, and that they left their shift that day without following up on the order. Staff member #107, #108 and the DOC #103 all confirmed that a telephone order should be transcribed immediately.

B) Resident #012 had an order for; an extended release twelve hour analgesic to be given twice daily. A review of the Medication Administration Audit Report (MAAR) showed that on a specified date, the medication was administered at an identified time. The MAAR showed that the next dose was not given until seventeen hours and twenty-four minutes later.

Staff member #107, #108 and the DOC #103, all shared that the expectation for a twelve-hour slow release medication was that the dose should be given twelve hours apart. [s. 131. (2)]

Additional Required Actions:

CO # - 005 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# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of all aspects of the infection prevention and control program.

Simcoe Muskoka District Health Unit (SMDHU) declared an enteric outbreak at the home on a specified date. The case definition determined by the symptoms that the home communicated were defined as: any staff or resident of Creedan Valley Care Community presenting with two or more episodes of vomiting and or diarrhea within a twenty-four period on or a confirmed case.

A) Upon arrival to the home by the inspection team, staff member #104, the infection control lead, provided the line list for residents and shared that resident #017, #037, and #038 remained in isolation without symptoms, and resident #039, #029 and #040 developed symptoms over the weekend and were added to the line list.

The progress notes for resident #024, stated that on a specified date, they were symptomatic with two episodes of enteric symptoms. The line list that the inspectors were given the following day, upon entry into the home did not have resident #024 included on the line list.

Staff member #104 shared they were unsure why resident #024 was not added to the line list when they became symptomatic.

B) Resident #026's progress notes indicated that they had received an anti-emetic medication on a specified date for nausea and an upset stomach. The following day, they had multiple episodes of enteric symptoms. Inspector #155 noted that resident #026's door did not have isolation precaution signage or personal protective equipment (PPE) on their door. Staff member #130 advised resident

#026, that they needed to stay in their room as they had two episodes of enteric symptoms the day before.

Staff member #126 and #129 shared that resident #026 was in the dining room the morning after they were sick, and that they were not aware that resident #026 was sick the evening before, did not get report, and that resident #026 was to be in isolation.

A review of the home's line list given to inspectors indicated that resident #026 was #23 on the list, their date of onset of vomiting was on a specified date, and two other residents became symptomatic and added to the line list after resident #026 was added.

C) Resident #041's progress notes indicated that on a specified date, they experienced two episodes of diarrhea. A review of their POC documentation that was completed by PSW's indicated that resident had one medium bowel movement (BM) and three large BM's, and the following day, they had one small BM and one large BM. The documentation in POC did not include the consistency of the bowel movements to determine the case definition of diarrhea. The progress notes for resident #041 indicated that one of the BM's, was of normal consistency for the resident.

Staff member #150 and #106 shared that PSW's do not document consistency of residents experiencing bowel movements, they used to, but now just inform the RPN. Staff member #150 shared that assessing and documenting the consistency of a BM is a key factor in documenting, especially when there is an outbreak occurring. Staff member #106 shared that they are not always communicated with as to the consistency of BM's and they should be.

RAI-Co-ordinator, and infection control lead #104 shared that they were not aware that PSW's did not document on the consistency of residents BM's and the nurses had to rely on the PSW's communicating with them. RAI-Co-ordinator #104 also shared that they removed resident #041 from isolation precautions one day after having two documented episodes of diarrhea. They indicated that they assessed resident #041, they had one BM that was normal and determined that they did not meet case definition.

Resident #041 was removed from isolation despite the criteria that was determined by public health at the commencement of the home's outbreak.

D) 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 – 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.

DOOE shared that they received the memo and were implementing an active screener at the front door on March 13, 2020. [s. 229. (4)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's monitoring of resident weights

policy was complied with.

A) Review of resident #025's weights recorded in Point Click Care (PCC) showed that on a specified date, resident #025 has specified weight gain in one month.

Review of the home's policy titled Monitoring of Resident Weights, policy number VII-G-20.90, revised April 2019, stated that monthly weights and re-weights were to be documented in the weights and vital section of the electronic record by the tenth of every month. Ensure that the PSW reweighed the resident if there was a weight change (loss or gain) or a 2 kg difference in the resident's weight from the previous month.

Staff member #106 shared that when the weights were entered into PCC weights and vitals section, and there was a discrepancy in the weight that caused a warning of a 5 percent weight change in the last month, then a reweigh was to be done. A review of resident #025's weights recorded in PCC was done as well as a review of POC documentation and progress notes, and there were no notations made that a reweigh for resident #025 had been done.

B) Review of resident #028's weights recorded in PCC showed that on a specified date, resident #028 had specified weight loss in one month.

A review of resident #028's weights recorded in PCC was done as well as a review of POC documentation and progress notes and there were no notations made that a reweigh of resident #028 had been done.

C) Review of resident #027's weights recorded in PCC showed that on a specified date, resident #027 has specified weight loss in one month.

A review of resident #027's weights recorded in PCC was done as well as a review of POC documentation and progress notes, and there were no notations made that a reweigh of resident #027 had been done.

On March 13, 2020, DOC #103 reviewed resident #025, #028 and #027's PCC records and shared that a reweigh should have been done for resident #025 by the tenth of the month and it had not.

The licensee failed to ensure that the home's monitoring of resident weights policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with. O. Reg. 79/10, s. 8 (1), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee failed to ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements in subsection (2); and had provided the licensee with proof of graduation issued by the education provider.

As per the LTCHA s.8 (2), personal support services means services to assist with the activities of daily living, including personal hygiene services, and included supervision in carrying out those activities.

On a specified date, the MLTC received an anonymous compliant stating that as of January 2020, Care Support Assistants (CSA) were now allowed to assist with, and provide personal support services to the residents such as dressing, oral care and bathing.

During this inspection it was noted that currently there were two CSA's that were working in the home. On the dates that these CSA's were working a review of the Daily Nursing Roster showed that they were assigned into a PSW assignment on every home area.

Staff member #139 shared that around January 7, 2020, the CSA's job duties changed in that they were given an assignment and could help in the tub room. They shared that CSA's were now allowed participate in areas of care that were previously restricted to PSW staff. Staff member #139 said that the CSA's were now doing the same job as the PSW.

On a specified date, staff member #106 shared that CSA #110 was working on a specified home area. They shared that CSA #110 was observed to have resident #031 seated on the toilet and to have only provided a portion of the required care then dressed the resident.

CSA #110 shared that they most often get assigned to work on two home areas and that they were given certain residents to look after. When on a specified home area some of the residents they look after were resident #030 and #031. CSA #110 stated that they direct the residents to brush their hair or teeth but when the resident did not, they did the care for the resident. CSA #110 shared that they could not remember exactly when their duties changed but they were now to perform duties that were previously restricted to PSW's, they were able to assist with transfers in and out of the bath, assist with personal care, and dress the residents. They said that they did all the same work as a PSW with the only difference being they were not allowed to perform peri-care on a resident.

CSA #140 shared that when they work evenings that they were not assigned residents but did help the PSW's with changing of the residents. They described that the PSW would provide personal care, but that they did help turn them in the

bed and assist with dressing. When on days, they shared that they would get a resident assignment and they would take the resident to the washroom, provide care, brush their teeth and/or remove dentures, and dress the resident. They shared that they put the lift slings under residents and get the resident's hooked to the lift to assist the other staff with lift. The PSW was usually with the resident while the CSA used the remote and control the lift.

Resident #031's care plan identified they required a specified level of care in various care areas. The documentation showed that the CSA provided care to the care areas and that they were to be completed by a PSW.

Review of resident #031's POC documentation was done. It was noted that on three specified dates, that CSA #110 documented care for resident #031.

Resident #030's care plan identified they required a specified level of care in various care areas. The documentation showed that the CSA provided care to the care areas and that they were to be completed by a PSW.

ED #101 shared that CSA's were not providing any hands on care. The CSA's were not to be washing, or dressing any residents. They shared that they were only to be with independent residents and set them up for care but not to assist them in any manner. They shared that the CSA's had an assignment list, but that the ED #101 could not find it, so they made one on March 12, 2020. Review of the CSA list did not have resident #030 or #031 on it. ED #101 also shared that there had been no auditing done of the CSA's as to what duties they were performing in the home.

The licensee failed to ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements in subsection (2); and had provided the licensee with proof of graduation issued by the education provider. [s. 47. (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 that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements in subsection (2), to be implemented voluntarily.

Issued on this 23rd day of October, 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 KIM BYBERG (729) - (A2)
Inspection No. / No de l'inspection :	2020_781729_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012219-19, 012221-19, 012224-19, 016339-19, 016340-19, 016341-19, 019704-19, 019705-19, 019706-19, 000524-20, 001994-20, 002443-20 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 23, 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 :	Chantal Carriere

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_545147_0007, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with c. 8, s. 6 (7) of the LTCHA.

Specifically, the licensee must:
a) Ensure that the care set out in the plan of care related to fall prevention is provided to resident #004, #019, and #021 and any other resident in the home, as specified in the plan.

b) Complete an audit that identifies the interventions in the plan of care for residents at moderate or high risk for falls is being provided to the residents as specified in their plans. The audits are analyzed and follow up actions are taken and documented to correct any deficiencies that are identified. The audits shall be kept available in the home.

c) Ensure that the care set out in the plan of care related to nutrition and hydration interventions are provided to resident #025, #028 and any other resident in the home, as specified in the plan.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #002 from inspection #2019_545147_0007, issued on October 24, 2019, with a compliance date of January 31, 2020.

The licensee was ordered to be compliant with s.6(7) of the LTCHA.

Specifically,
A) The licensee was to ensure that the care set out in the plan of care related to falls prevention was provided to resident #001, #004, #005, #006 and #032 and any other resident in the home as specified in their plan.

B) The licensee was ordered to ensure an auditing process was developed and fully implemented to ensure that the plan of care for residents at moderate or high risk for falls was provided to the residents as specified in their plans. This auditing process was to be documented and was to include 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 in regard to the audit results. The audit was to be kept in the home.

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #004, #019 and #021 as specified in the plan.

A) Resident #021 was at moderate risk for falls with multiple documented falls since their admission.

A post fall assessment documented they were found sitting on the floor and could not reach the call bell.

Resident #021's plan of care stated to ensure their call bell was within reach. After their fall on a specified date, the plan of care was updated to include fall interventions to improve safety with transfers.

One month later, it was observed that resident #021's call bell was not within reach.

According to resident #021, where they sit during the day they are not able to reach the call bell. They also confirmed that after a recent room change, the new fall interventions were not re-installed.

Staff member #144 was unsure what the fall prevention interventions were for resident #021. Staff member #144 confirmed that the call bell could not be reached at the location that the resident usually sits at during the day. They also said that occasionally resident #021 was unable to move from their chair and would throw an identified object out the door to indicate assistance was required. Staff member #144

said this was not a safe method of calling for assistance.

B) Resident #019 was at moderate risk for falls, with a history of multiple falls in 2019. Fall prevention interventions in their plan of care included to ensure that when resident #019 was in bed, specific fall injury prevention interventions were to be in place.

On a specified date, resident #019 was observed sleeping in their bed without their safety interventions in place. Staff member #154 said they had just assisted resident #019 to bed and acknowledged that they forgot to ensure the safety intervention was in place.

IADOC #141 said staff did not follow the resident's plan of care on two specified dates and they also observed the same issue.

C) Resident #004 was at moderate risk for falls. The plan of care indicated that resident #004 was to have a wheel chair alarm on their chair.

On a specified date, resident #004 was observed with their wheelchair clip alarm attached to their chair and not to them specifically. The clip alarm remained unclipped.

IADOC #141 confirmed that resident #004 was to have a clip alarm and the alarm was to be be clipped to them whenever they were in their wheelchair.

D) Compliance order #002 from inspection #2019_545147_0007 required the home to complete an audit to ensure the plan of care for residents at moderate or high risk for falls was provided to residents as specified in the plan of care. IADOC #141 and CP #142, said they were unable to provide documentation for the audit as the home did not have the information that was being requested as specified in the compliance order.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #021, #019 and #004 as specified in their plan.

The licensee also failed to develop an audit system as ordered in the home's compliance order to ensure that the plan of care for residents at moderate to high

risk for falls was provided to the residents as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that documentation into resident #003 and #023's electronic treatment administration record (eTAR) was documented as set out in the plan of care.

A) Resident #003 had multiple areas of impaired skin integrity that had prescribed treatments ordered and entered into the eTAR that required the nursing staff to complete and document the treatment.

Resident #003's eTAR for a specified month, showed that resident had skin impairment and to administer a prescribed treatment one time per day. The eTAR showed that on six days of the month, there was no documentation that the treatment was completed.

Resident #003 had a second skin impairment with a prescribed treatment to be completed every two days. The eTAR for the specified month showed three times in the the month that there was no documentation that the treatment was completed.

Resident #003 had a third area of skin impairment and a physician order was to be completed twice per day The eTAR for a specified month showed six days in the month the prescribed treatment was not completed.

A review of resident #003's progress notes did not indicate that any treatments were completed on the specified dates.

Staff member #107 shared that all treatments that were completed would be documented in the eTAR, and if it was not signed in the eTAR there should be a progress note of the treatment provided.

B) Staff members #109, #133 and IADOC #141 stated that treatments for altered skin integrity were found and documented in a resident's eTAR.

Resident #023's eTAR showed they had areas of altered skin integrity that required a treatment every other day. There was no documentation on the eTAR or progress notes to show the treatment had been provided for four days in the specified month for one area of impairment and no documentation for three days on the second area

of altered skin integrity.

Staff members #109 and #133 reviewed resident #023's February 2020 eTAR with Inspector #738. They acknowledged there was no documentation to show the treatments identified above had been provided.

IADOC #141 believed that staff were completing resident #023's treatments as required because their altered skin integrity was improving but they not document it.

The licensee has failed to ensure that documentation into resident #003 and #023's electronic treatment administration record (eTAR) was documented as set out in the plan of care. [s. 6. (9) 1.]

3. The licensee failed to ensure that the provision of the care set out in the plan of care was documented for resident #028.

On a specified date, resident #028 was observed by inspector #155 during lunch meal. Resident #028 was assisted by staff member #153. Resident #028 took 0.75 servings of soup, two servings of orange liquid and fifty percent of their main course.

Review of resident #028's food and fluid documentation done in POC for the specified date, showed that there was no documentation done for the breakfast or lunch meals.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented for resident #028.

(743)

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #025 and #028 as specified in the plan.

A) Resident #025's current care plan and annual nutritional assessment completed on a specified date, stated that resident #025 was to receive high protein (HP) drink, two servings at meals to promote weight maintenance/gain.

On a specified date, during breakfast resident #025 was observed by inspector #729.

Resident #025 was not offered any HP drink during the breakfast meal. However it was documented that they had a serving.

On a specified date, during lunch resident #025 was observed by inspector #729. Resident #025 was not offered any HP drink during the lunch meal. However, their intake was documented as one serving. fluid.

B) Resident #028's dietary assessment note in PCC on a specified date, stated that resident #028 was to receive HP milk two servings at meals to promote weight maintenance.

On a specified date, during lunch resident #028 was observed by inspector #155. Resident #028 was not offered any HP drink during the lunch meal.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #025 and #028. [s. 6. (7)]

The severity of this issue was determined to be a level 2 as there was minimal risk or harm to the residents. The scope of the issue was a level 2 as it related to four of nine residents reviewed. The home had a level 5 history of on-going noncompliance with this subsection of the Act that included:

Voluntary Plan of Correction (VPC) issued November 24, 2017, (2017_641513_0014);
VPC issued August 28, 2018, (2018_742527_0013);
VPC issued August 29, 2018 (2018_742527_0012);
VPC issued September 11, 2018, (2018_760527_0019);
Compliance Order (CO) issued May 22, 2019, (2019_773155_0007);
CO issued August 15, 2019, (2019_545147_0007)
Additionally, the LTCH has a history of 32 other compliance orders in the last 36 months.
(155)

(155)

Dec 20, 2020(A2)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

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: 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0007, CO #008;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with s.76(2) of the LTCHA.
Specifically, the licensee must:

a) Ensure that staff member #113, #114, #115, #116 and the DOC #103 receive the required training as outlined by this section of the LTCHA.
b) Ensure that the homes policy to promote zero tolerance of abuse and neglect of residents are included in the training, and records of the training completed are kept in the home.
c) Ensure that each staff member hired by the home and any new staff member working in the home are provided training as required by this section of the LTCHA prior to performing their duties. Records of the training completed by each staff member must recorded and available at the home.

Grounds / Motifs :

1. The licensee failed to be compliant with CO #008 from inspection #2019_773155_0007 with a compliance due date amended of January 31, 2020.

The licensee was ordered to be complaint with s. 76 (2). of the LTCHA.
Specifically,

a) Ensure that agency Registered Nurse (RN) #153, #154, #155, #156, #157, #158, #159; and agency Registered Practical Nurse (RPN) #103, #160, #161 and #162, as well as any other agency staff and all other staff at the home, do not perform their responsibilities before receiving training in the following areas:
1. The Resident's Bill of Rights;
2. The long-term care home's mission statement;
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
4. The duty under section 24 to make mandatory reports;
5. The protections afforded by section 26;
6. The long-term care home's policy to minimize the restraining of residents;
7. Fire prevention and safety;
8. Emergency and evacuation procedures;
9. Infection prevention and control;
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.; and
11. Any other areas provided for in the regulations.

b) The training will be documented and the training records, for agency RN #153, #154, #155, #156, #157, #158, #159; and agency RPN #103, #160, #161 and #162, as well as any other agency staff and all other staff at the home, will be kept in the home.

1. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
7. Fire prevention and safety.
9. Infection prevention and control.

Director of Programs and Admissions (DOPA) #119 said staff were required to complete Relias training, and in-person fire prevention and safety training prior to performing their duties. They said this training included education on the areas mentioned above.

A) Records showed that staff member #115 was hired at the home on a specified date, and worked at the home three days later. They did not receive training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents or fire prevention and safety training prior to performing their duties.

B) Records showed that staff member #116 was hired at the home on a specified date, and worked at the home two months later. They did not receive training on the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, fire prevention and safety, and infection prevention and control prior to performing their duties.

C) Records showed that staff member #113 and #114 were hired at the home on a specified date, and worked at the home three weeks later. They did not receive training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their duties.

D) Records showed that DOC #103 was hired at the home on September 3, 2020.

They did not receive training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their duties.

DOPA #119 confirmed staff members #115, #116, #113, #114, and DOC #103 did not receive training in the above mentioned areas prior to performing their duties.

DOPA #119 and Director of Operational Effectiveness (DOOE) #102 said an error had occurred and the home's policy to promote zero tolerance of abuse and neglect was not programmed in Relias to be delivered annually. They said this error led to the above mentioned staff not receiving abuse and neglect training prior to performing their duties.

The licensee has failed to ensure that staff members #115, #116, #113, #114, and DOC #103 received training in the areas mentioned below prior to performing their responsibilities:

1. The Residents' Bill of Rights.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
7. Fire prevention and safety.
9. Infection prevention and control. [s. 76. (2)]

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 five out of five staff not trained prior to performing their duties. The home had a level 5 history of on-going non-compliance with this section of the Act that included:

Compliance order (CO) issued August 29, 2018, (2018_742527_0012);
CO issued May 22, 2019, (2019_773155_0007)
Additionally, the LTCH has a history of 32 other compliance orders in the last 36 months.
(738)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 20, 2020(A2)

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 #012;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

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

The licensee must be compliant with O.Reg 79/10 s. 31 (3).
Specifically, the licensee must:

a) Ensure the written staffing plan required for the organized program of nursing services and the organized program of personal support services under clause 8(1)(b) of the Act, provides for a staffing mix that is consistent with residents assessed care and safety needs.

b) Ensure the revised staffing plan, including the revised staffing back-up plan is implemented and complied with.

c) The licensee must ensure ongoing recruitment to fill vacant positions. Develop a tracking tool regarding staff recruitment that is documented and includes at a minimum the type of position vacant, date the position became vacant, date recruitment efforts started for this position, what recruitment efforts are done for each vacant position and dates these efforts were done and outcome of the efforts.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #012 from inspection #2019_773155_0007 issued on May 22, 2019, with a compliance due date of January 31, 2020.

The licensee was ordered to be compliant with O.Reg 79/10 s.31(3)(a).
Specifically, the licensee must:

a) Ensure the written staffing plan required for the organized program of nursing services and the organized program of personal support services under clause 8(1)(b) of the Act, provides for a staffing mix that is consistent with residents assessed care and safety needs.
b) Develop, document and implement a process in the home for the leadership to evaluate, at a minimum of bi-weekly, whether the written staffing plan is consistently meeting the residents assessed care and safety needs in the home.
This evaluation must include:
i) An analysis of the care and safety needs of each group of residents in each section of the home which includes, but is not limited to, the residents' care needs related to Activities of Daily Living (ADLs) including toileting and continence care; responsive

behaviours; assistance with transfers, mobility and positioning; skin and wound care; falls prevention and bathing.
ii) An analysis of whether the written staffing plan for each section of the home, as per the staff assignment sheet, is meeting the care and safety needs of all residents living in the home.
iii) A documented record of the staffing plan evaluation which includes the date it was conducted, the names and signatures of the participants, the information analyzed, the results of the evaluation and what was done with the results of the evaluation.

c) Ensure the evaluation includes analyzing the variances related to vacant registered and PSW positions including the back-up plan.

d) Ensure the revised staffing plan, including the revised staffing back-up plan is implemented and complied with.

The licensee failed to complete steps a) and d).

1. The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

DOC #103 and ED #101 both shared that the PSW staffing plan was:
Days - 10 PSWs working 0600-1400 hours;
Evenings - 10 PSWs working 1400-2200 hours; and
Nights - 2 PSWs working 2200-0600 and 2 PSWs working 2300-0700 hours.

ED #101 shared that when Care Service Assistants (CSA) work they are not counted as PSW's, and that they were in their own category. They also stated that the staffing complement had not changed even with the twelve empty beds so that resident care should be seamless.

Scheduling Coordinator #112 provided the reconciled Daily Nursing Rosters for the period of February 1, 2020, to March 6, 2020. Review of the reconciled Daily Nursing Rosters for the period of February 1 to March 6, 2020 was done.

For the period of February 1 to February 14, the home had 180 vacant PSW hours.
For the period of February 15 to February 28, the home had 195 vacant PSW hours.

For the period of February 29 to March 6, the home had 150 vacant PSW hours.

The staffing shortages impacted resident care in multiple areas:

A) Assistance at meals:
The posted meal times stated that breakfast was at 0830 hours, lunch at 1230 hours and supper at 1700 hours.

i) On a specified date, there were 7 PSW's working during the day shift and the usual staffing is 10. Resident #020 and resident #042 were observed in the large dining room to be served their soup at 1302 hours.
-Resident #013 was not offered any soup and was given their main course at 1302 hours.
-Lunch finished at 1358 hours, one hour and 28 minutes after the start of meal service.
-There were nine residents on enteric isolation

ii) On a specified date, resident #020 was served breakfast at 0913 hours.
-Breakfast finished at 0945 hours.
-Lunch finished at 1400 hours.
-There were nine residents on enteric isolation.

iii) On a specified date, resident #020 was saying that they were hungry. Soup was served to resident #020 at 1315.
-Resident #044 who required to be fed by staff received this help at 1315 hours.
-Resident #013 was not offered soup, was given the main course and fed by staff.
-Resident #021 shared that breakfast and lunch were for the most part always one-half hour late. They shared breakfast was to be at 0830 and it did not usually start until 0900 hours or later, and lunch was to be at 1230 hours and it did not usually start until 1300 hours. They expressed that during the outbreak that coffee club was cancelled, and when they were use to getting a coffee around 0700 hours, they expressed that having to wait until 0900 hours or later for a coffee was a long time.

iv) On a specified date, breakfast finished at 0940 hours and the tea cart started to be served at 1002 hours.
-At lunch resident #029 and #044 were served their soup at 1308 hours.
-Residents #017, #020 and #025 were served their fluids at 1311 hours.

-Residents #017 and #025 who required to be fed by staff, received assistance with their lunch at 1324 hours, 54 minutes after the start of meal service.
-There were four residents in enteric isolation.

v) On a specified date, resident #028 who was in enteric isolation was not fed their breakfast tray. Staff member #134 shared that they had forgot to feed resident #028 their breakfast tray.

vi) On a specified date, breakfast started at 0900 hours. At 0904 hours, RAI-Coordinator #104 served resident #045 their breakfast and sat to feed them at table one. No other residents where noted at table one. When inspector #155 inquired as to where resident #046 was, staff member #124 went and got resident #046 from their room. RAI-Coordinator #104 then got resident #046 their breakfast and started to feed them.

B) Personal Care

i) On a specified date, resident #032 was given a basin of water and left with their clothes beside them on the bed at 0850 hours. At 0908 hours resident #032 remained sitting on side of bed in front of basin crying at times while trying to dress. Resident #032 was observed at 1125 hours and 1455 hours and did not have socks on.

ii) On a specified date, there were 9 PSWs working during the day shift. Resident #017 was removed from isolation on this day and PSW staffing on one specific unit was all agency staff. Resident #017 was observed to have matted hair. DOOE #102 agreed that resident #017's hair was not clean and groomed and later shared that they had the staff take resident #017 to the spa room to have their hair washed.
-There were 10 residents on enteric isolation

C) Bathing

i) Staff member #124 shared that resident #004 was not bathed on the day shift on a specified date, as per the bath schedule due to time constraints as there were only two PSW's on the unit during day shift.

D) Toileting Routines

i) Resident #043 shared that they often had to wait for 20 minutes after they rang their call bell after meals to get assistance to go to the bathroom. They shared that they often had an accident by the time the staff were able to get to them to assist them to the bathroom.

ii) On a specified date, resident #006 rang their call bell at 1322 hours asking to go to the bathroom and then to bed. Staff member #133 responded at 1325 hours, and said they would get some help. At 1335 hours, resident #006 rang their call bell asking to go to the bathroom and bed. At 1340 hours, staff member #133 answered the bell and said they would get some help. At 1343 hours, resident #006 rang their call bell and staff responded at 1345 hours helping resident #006 to the bathroom and then to bed.
-There were six residents in enteric isolation.

A number of staff members expressed that when they do not have their full complement of staff on their shift that managers do not come and assist in the dining rooms. They shared that if they do express that they do not have their full complement of staff and ask for help, they are told that they are twelve beds down so they should not have a problem getting their work done.

During interview with ED #101, they shared that they had one part time night RN position, one full time RPN position, and twenty-two vacant PSW positions. Of the twenty-two vacant PSW positions, four were for full time days, three were for full time evenings, four were for part time days, seven were for part time evenings and 4 were for part time nights. They shared that they enter the postings in Ultipro and that puts them on Sienna's web site and also on the Indeed website.

Review of Sienna's web site and Indeed web site was done. There were no postings noted for the RN or any PSW positions.

ED #101 shared that they had been doing the bi-weekly reviews of the staffing plan.

A Review of the ED's review of the staffing plan was done. Analysis and evaluation of the staffing plan dated January 31, 2020, stated that the bathing schedule was reviewed and updated to reflect staffing levels February 20, 2020. Staffing plan revised January 23, 2020, by home area. Quality indicators reviewed and falls

reviewed by home area. Trillium Way was noted to have the highest falls rate with an average of eight falls, Poppy Lane with an average of five falls and Lilly Way and average of three to five falls. "We continue to have full compliment of staff for each home area."

The analysis and evaluation of staffing plan dated February 14, 2020, stated that review of the staffing for the month of January 2020, was done. The home continued to complete interviews for ADOC, ESM, RN, RPN and PSWs. The home continued to bring in agency on an average of nine to fourteen PSW agency staff working every day. They continued to have town hall meetings for all shifts during the month of January 2020.

The analysis and evaluation of the staffing plan dated March 2, 2020, stated the home continued to monitor daily missed shifts. Review of staffing for the month of February 2020, was done and noted that RN missed shifts were seven and these were covered by the DOC, RPN missed shifts were three and these were covered by the RAI/ADOC, and PSW missed shifts were twelve on days, four on evenings, four on nights and Care Support Assistant had one missed shift. On average the home uses nine to fifteen agency PSWs, RPNs and RN in a given 24-hour period. The resident census was eighty-three and the complement of staff has not changed.

Review of the reconciled Daily Nursing Rosters for the period of February 1 to February 29, 2020, for PSW missed shifts was done. The review showed there were:
-32.5 missed shifts on days;
-18 missed shifts on evenings;
-4 on nights.

The analysis and evaluation of the staffing plan dated March 2, 2020, also stated that the ESM position remained vacant and the ADOC, RPN and PSW was hired.

ED #101 shared that the DOC had educated the staff on the back-up staffing plan/contingency plan and that it was available in the resource binder on the nursing units. When asked what the minimum number of staff that were allowed on each shift ED #101 shared that if they were down to half the staff on days and evenings it would be unreasonable to ask their staff to do that, and at that point managers would come in to help. On the night shift they would have a manager come in only if they had 1 RN and 2 PSW's in total for 3 homes areas.

DOC #103 shared that the back-up staffing plan/contingency plan had evolved over time and it was placed in the staff phone number book or resource binder and that it was still being rolled out. They stated that they wanted staff to give feedback on it. When asked what the minimum number of staff that were allowed on each shift before managers would come in to work, DOC #103 shared that on days or evenings if they were 3 or 4 PSW's down, than the call goes to the manager on call. If they were not able to get anyone to come in, then they would get activity staff to pitch in. If they had more than 3 PSW's down, then the nursing managers needed to be in the dining room helping.

A review of the back-up staffing plan/contingency plan identified the plan/strategy and the duties that must be done for staff vacancies. There was nothing in the staffing plan/contingency plan as to who was to assist or come in to work if the home was 4 or 5 PSW's down.

Staff member #133 was shown the back-up staffing/contingency plan that was placed in the staff phone number book or resource binder. They shared that they had never seen the document and had not been educated on it. Staff member #106 shared that the back-up staffing/contingency plan was put into the resource binder the week of March 2, 2020. They shared that they had no education or instruction about the plan.

The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs. [s. 31. (3)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3 as it related to all residents in the home. The home had a level 5 history of on-going non-compliance with this subsection of the Act that included:

Compliance Order (CO) #004 issued August 29, 2018, (2018_742527_0012);
CO #012 issued May 22, 2019; (2019_773155_0007);
Additionally, the LTCH has a history of 32 other compliance orders in the last 36 months.

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

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 20, 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_781729_0018, CO #002;

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 #004, #008, #014 and all other residents are bathed by the method of their choice at a minimum twice per week.

b) Ensure that the residents #004, #008, #014 and all other residents' plan of care clearly states their bathing preference. Any deviation for their bathing preference shall be documented in the residents' clinical record at time of the deviation.

c) Ensure that staff member #113 and all other nursing and personal care staff receive training on the use of the shower chair provided for showering residents and ensure that the training on the use of the shower chair is added to all nursing and personal care staff orientation checklists.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #002 from inspection # 2019_781729_0018 issued October 3, 2019, with a compliance due date of January 31, 2020.

The licensee was ordered to be compliant with O.Reg 70/10, s. 33(1).

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, ap 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 manes 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.

The licensee completed step b) and c) of compliance order #002.

1. The licensee failed to ensure that resident #004, #008 and #014 were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) Resident #004's care plan stated that their preference was a tub bath twice weekly, but due to impaired skin integrity, resident #004 was to receive a shower twice weekly.

Review of the bath schedule showed that resident #004 was to have a bath on specific days.

Resident #004's POC bathing documentation for one month, showed that resident #004 had a tub bath on specified dates. There was no documentation in resident #004's progress notes as to why resident #004 was given a tub bath and not a shower as per the care plan.

Staff member #123 and #124 shared that they refer to the bath schedule, and care plan to find out the bathing preference for residents. Review of the bath schedule and care plan was done with staff member #119, and they shared that the bath

schedule was not updated to reflect that resident #004 was to have a shower, and that resident #004 should have had showers and not tub baths. Staff members #123, #124 and #119 all shared that when a resident was not given their bathing preference, the registered staff were to be notified, and enter a progress note, or if comfortable, the staff member could enter the progress note themselves as to why the resident was not given their bathing preference.

Bathing audits were completed for resident #004 but they did not capture that resident #004 was not getting their shower as per the plan of care as the bath schedule indicated that resident #004 was to get a tub bath.

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

Review of the bath schedule for showed that resident #008 was to have a tub bath on Thursdays and Sundays.

Resident #008's POC bathing documentation for one month, showed that resident #008 had a shower on on two specified dates. There was no documentation in resident #008's progress notes as to why resident #008 was given a shower and not a tub bath as per the care plan.

Staff member #123 and #124 shared that they refer to the bath schedule and care plan to find out the bathing preference for residents.

Review of the bath schedule and care plan was done with staff members #123 and #124 and they shared that resident #008's bathing preference was a tub bath. Staff members #123, #124 and #119 all shared that when a resident was not given their bathing preference the registered staff were to be notified and enter a progress note, or if comfortable the staff member could enter the progress note themselves as to why the resident was not given their bathing preference.

Staff member #119 shared that resident #008 did not get their bathing preference of a tub bath on the specified dates and there was no progress notes made as to why they were given a shower.

Bathing audits were completed for resident #008 which showed they had a shower

on a specified date, as they were on enteric isolation and there was no action/follow up noted. The bathing audit on a specified date, showed that resident #008 got a shower and there was no action/follow up noted. Staff member #119 shared that follow up with staff member #126 was done and that staff member #126 shared that a shower was given because the tub room was busy.

C) Resident #014 shared that their bathing preference was a tub bath twice weekly. When asked why they were receiving showers they shared that staff told them that the tub room was all booked up.

Staff member #119 and #123 shared that resident #014 could express what their bathing preference was and if they changed their preference from what the care plan or bath schedule indicated, staff were to offer resident #014 what they requested at the time of offer.

Review of the bath schedule showed that resident #014 was to have a shower on Tuesdays and Saturdays. Review of resident #014's care plan stated that their preference was a shower.

Resident #014's POC bathing documentation for one month, showed that resident #014 had a tub bath on two dates. There was no documentation in resident #014's progress notes as to why resident #014 was given a tub bath instead of a shower. On eight specified dates, resident #014 was given a shower however they stated their preference is a tub bath.

Staff member #141 shared that resident #014 told them that they were given a shower by staff because it was more convenient for the staff.

The licensee failed to ensure that resident #004, #008 and #014 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. [s. 33. (1)]

The severity of this issue was determined to be a level 1 as there no harm to the residents. The scope of the issue was a level 3 as it related to three of four residents reviewed. The home had a level 5 history of on-going non-compliance with this subsection of the Act that included:

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

Compliance Order (CO) #005 issued August 29, 2018, (2018_742527_0012);
CO #013 issued May 22, 2019, (2019_773155_0007);
CO #002 issued October 3, 2019, (2019_781729_0018)
Additionally, the LTCH has a history of 32 other compliance orders in the last 36 months. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 07, 2020

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: 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The Licensee must be compliant with r. 131 (2) of O. Reg. 79/10.

Specifically, the licensee must:
a) Ensure that drugs are administered to resident #001 and #002 and all other residents in accordance with the directions for use as specified by the prescriber
b) Ensure that all orders prescribed by the prescriber that are taken over the telephone, fax, or any other method of communication, that the order is transcribed immediately into resident #001, and #002 and all other residents clinical record.
c) Ensure that any new or existing prescribed medication is transcribed, processed and checked in accordance with the home's policies.

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

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber for resident #001 and resident #012.

A) On a specified date, a Critical Incident (CI) was reported to the Ministry of Long-Term Care (MLTC) regarding the improper/incompetent treatment of a resident that resulted in harm or risk of harm to the resident. The report stated that a medication order was received for resident #001, but that it was not transcribed. The resident was sent to hospital and admitted.

Staff member #107 confirmed that they did not transcribe or process the telephone order for resident #001, and that they left their shift that day without following up on the order. Staff member #107, #108 and the DOC #103 all confirmed that a telephone order should be transcribed immediately.

B) Resident #012 had an order for; an extended release twelve hour analgesic to be given twice daily. A review of the Medication Administration Audit Report (MAAR) showed that on a specified date, the medication was administered at an identified time. The MAAR showed that the next dose was not given until seventeen hours and twenty-four minutes later.

Staff member #107, #108 and the DOC #103, all shared that the expectation for a twelve-hour slow release medication was that the dose should be given twelve hours apart. [s. 131. (2)]

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 2 as it related to two of three residents. The home had a level 3 history of on-going non-compliance with this subsection of the Act that included:

-Voluntary Plan of Correction (VPC) issued May 22, 2019, (2019_773155_0007)
Additionally, the LTCH has a history of 32 other compliance orders in the last 36 months.
(766)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 20, 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: 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (4)

Specifically, the licensee must:

a) Ensure that all residents experiencing symptoms as defined in the case definition as determined in collaboration with Public Health representative are added to the home's daily line list.
b) Develop a communication tool that provides updated communication immediately to all members of the health care team when residents become symptomatic, and ensure education is provided to the team members on the appropriate precautions to take.
c) Develop a documentation tool to ensure that front line care providers are able to access and document all symptoms of enteric and respiratory symptoms that residents may be experiencing.
d) Ensure that any directive communicated to the home by Public Health Ontario or the Ministry of Long Term Care is implemented immediately as per the timelines outlined in the directives.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of all aspects of the infection prevention and control program.

Simcoe Muskoka District Health Unit (SMDHU) declared an enteric outbreak at the home on a specified date. The case definition determined by the symptoms that the home communicated were defined as: any staff or resident of Creedan Valley Care Community presenting with two or more episodes of vomiting and or diarrhea within

a twenty-four period on or a confirmed case.

A) Upon arrival to the home by the inspection team, staff member #104, the infection control lead, provided the line list for residents and shared that resident #017, #037, and #038 remained in isolation without symptoms, and resident #039, #029 and #040 developed symptoms over the weekend and were added to the line list.

The progress notes for resident #024, stated that on a specified date, they were symptomatic with two episodes of enteric symptoms. The line list that the inspectors were given the following day, upon entry into the home did not have resident #024 included on the line list.

Staff member #104 shared they were unsure why resident #024 was not added to the line list when they became symptomatic.

B) Resident #026's progress notes indicated that they had received an anti-emetic medication on a specified date for nausea and an upset stomach. The following day, they had multiple episodes of enteric symptoms. Inspector #155 noted that resident #026's door did not have isolation precaution signage or personal protective equipment (PPE) on their door. Staff member #130 advised resident #026, that they needed to stay in their room as they had two episodes of enteric symptoms the day before.

Staff member #126 and #129 shared that resident #026 was in the dining room the morning after they were sick, and that they were not aware that resident #026 was sick the evening before, did not get report, and that resident #026 was to be in isolation.

A review of the home's line list given to inspectors indicated that resident #026 was #23 on the list, their date of onset of vomiting was on a specified date, and two other residents became symptomatic and added to the line list after resident #026 was added.

C) Resident #041's progress notes indicated that on a specified date, they experienced two episodes of diarrhea. A review of their POC documentation that was completed by PSW's indicated that resident had one medium bowel movement (BM) and three large BM's, and the following day, they had one small BM and one

large BM. The documentation in POC did not include the consistency of the bowel movements to determine the case definition of diarrhea. The progress notes for resident #041 indicated that one of the BM's, was of normal consistency for the resident.

Staff member #150 and #106 shared that PSW's do not document consistency of residents experiencing bowel movements, they used to, but now just inform the RPN. Staff member #150 shared that assessing and documenting the consistency of a BM is a key factor in documenting, especially when there is an outbreak occurring. Staff member #106 shared that they are not always communicated with as to the consistency of BM's and they should be.

RAI-Co-ordinator, and infection control lead #104 shared that they were not aware that PSW's did not document on the consistency of residents BM's and the nurses had to rely on the PSW's communicating with them. RAI-Co-ordinator #104 also shared that they removed resident #041 from isolation precautions one day after having two documented episodes of diarrhea. They indicated that they assessed resident #041, they had one BM that was normal and determined that they did not meet case definition.

Resident #041 was removed from isolation despite the criteria that was determined by public health at the commencement of the home's outbreak.

D) 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 – 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.

DOOE shared that they received the memo and were implementing an active screener at the front door on March 13, 2020. [s. 229. (4)]

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 residents in the

home. The home had a level 3 history of on-going non-compliance with this subsection of the Act that included:

-Voluntary Plan of Correction (VPC) issued August 28, 2018, (2018_742527_0013) Additionally, the LTCH has a history of 32 other compliance orders in the last 36 months.
(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 07, 2020

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

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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.

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

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

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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 23rd day of October, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KIM BYBERG (729) - (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