

**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**

Central West Service Area Office  
1st Floor, 609 Kumpf Drive  
WATERLOO ON N2V 1K8  
Telephone: (888) 432-7901  
Facsimile: (519) 885-2015

Bureau régional de services de Centre  
Ouest  
1e étage, 609 rue Kumpf  
WATERLOO ON N2V 1K8  
Téléphone: (888) 432-7901  
Télécopieur: (519) 885-2015

**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 12, 2021	2021_836766_0005	001886-21	Complaint

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**Licensee/Titulaire de permis**

2063412 Ontario Limited as General Partner of 2063412 Investment LP  
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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**Long-Term Care Home/Foyer de soins de longue durée**

Creedan Valley Care Community  
143 Mary Street Creemore ON L0M 1G0

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

KATY HARRISON (766), SHARON PERRY (155)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): February 9-11, 17, 2021.**

**The following intakes were completed during this inspection:**

**Log #001886-21, related to abuse and neglect of a resident.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), RPN Student, Personal Support Worker (PSW).**

**The inspector (s) also reviewed, progress notes; point of care records; daily huddle sheets; lab reports; records, policies and procedures.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation**

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

**1 WN(s)**

**0 VPC(s)**

**1 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

The licensee has failed to ensure that a resident was protected from neglect by staff when they did not have any urine output.

Section 5 of the Ontario Regulation 79/10 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

The Practical Nursing Student and a RPN documented that the resident had no urine output on their shift. This information was passed on to the nurse on the next shift. There were no attempts made to address the concern.

A review of the resident's intake record showed that their average fluid intake was consistently below their daily goal despite an order to offer/encourage extra fluids.

The physician was not notified that the resident did not have any urine output. The resident was transferred to hospital and admitted.

Sources: progress notes, point of care fluid intake and foley output records, daily huddle sheets; lab reports, history and physical from CG&M Hospital, Catheter Care Policy (dated April 2019), Quick Reference Guide for Low Fluid Intake, Prevention of Abuse & Neglect of a Resident Policy (dated April 2019); interviews with a RPN, PN Student and other staff.

***Additional Required Actions:***

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

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**Issued on this 19th day of March, 2021**

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

**Original report signed by the inspector.**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

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

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** KATY HARRISON (766), SHARON PERRY (155)

**Inspection No. /**

**No de l'inspection :** 2021\_836766\_0005

**Log No. /**

**No de registre :** 001886-21

**Type of Inspection /**

**Genre d'inspection:** Complaint

**Report Date(s) /**

**Date(s) du Rapport :** Mar 12, 2021

**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 :** Sadie Friesner

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**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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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:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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)

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

Specifically, the licensee must:

- a) Ensure that all registered staff and personal support workers caring for the resident have reviewed the relevant policy, related to urine output, dated April 2019 and that they are aware of their roles and responsibilities. A record of this review should be kept in the home and include the names of the staff and the date of the review.
- b) Ensure that registered staff are aware of the resident's urine output at a minimum of once during an eight-hour shift and that this is reported to the oncoming registered staff at shift change. Any actions taken in relation to output should be documented.
- c) Ensure that when the resident consumes less than 1000 mls of fluid in 24 hours that this information is shared with the care team and any assessments and actions taken are recorded in the resident's clinical record.

**Grounds / Motifs :**

- 1. The licensee has failed to ensure that a resident was protected from neglect by staff when they did not have any urine output.

Section 5 of the Ontario Regulation 79/10 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

The Practical Nursing Student and a RPN documented that the resident had no



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urine output on their shift. This information was passed on to the nurse on the next shift. There were no attempts made to address the concern.

A review of the resident's intake record showed that their average fluid intake was consistently below their daily goal despite an order to offer/encourage extra fluids.

The physician was not notified that the resident did not have any urine output. The resident was transferred to hospital and admitted.

Sources: progress notes, point of care fluid intake and urine output records, daily huddle sheets; lab reports, history and physical from CG&M Hospital, relevant Policy (dated April 2019), Quick Reference Guide for Low Fluid Intake, Prevention of Abuse & Neglect of a Resident Policy (dated April 2019); interviews with a RPN, PN Student and other staff.

An order was made by taking the following into account:

**Severity:** The severity of the issue was actual harm to the resident as they were transferred to hospital due to decreased level of consciousness and no urine output.

**Scope:** The scope of the issue was isolated as it related to one of the three residents reviewed.

**Compliance History:** The home had a history of on-going non-compliance with this subsection of the Act that included:

Compliance Order (CO) issued August 28, 2018, (2018\_742527\_0013);  
CO issued October 25, 2019, (2019\_781729\_0018)  
Written Notification (WN) issued October 31, 2019, (2019\_781729\_0020);

Additionally, the LTCH has a history of 45 other compliance orders in the last 36 months.

(155)

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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 :**

Mar 31, 2021

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

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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:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).

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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, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

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section 154 of the *Long-Term  
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2007, c. 8

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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 révision  
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](http://www.hsarb.on.ca).

**Issued on this 12th day of March, 2021**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Katy Harrison

**Service Area Office /**

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