Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Feb 22, 2019	2019_759502_0005	007783-18, 008075-18, 008097-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Deerwood Creek Care Community
70 Humberline Drive ETOBICOKE ON M9W 7H3

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

JULIENNE NGONLOGA (502), JOANNA WHITE (727)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): January 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, 31, 2019, and February 1, 2019.

The following intakes were inspected:
- One complaint (#007783-18) related to nutrition and hydration.
- Two complaints (#008075-18 and #008097-18) related to disease outbreaks.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Director of Dietary Services (DDS), Dietary Aid (DA), Registered Dietitian (RD), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator and family members.

The inspector(s) observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, staff schedule and home’s policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On an identified date in 2018, a complaint and a Critical Incident System (CIS) were submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to disease outbreak and staffing shortage.

Record review of the home's Respiratory Outbreak line list indicated the home had a respiratory outbreak for an identified three weeks period in 2018, residents #004, #012, and #013 were identified on this line list.

Review of resident #004's health record indicated that they experienced specified symptoms of infection for ten days during the period of the home's Respiratory Outbreak mentioned above.
Review of resident #004's progress notes for the period mentioned above indicated that the resident's signs and symptoms of infection were not monitored on eight occasions during specified days and shifts.

Review of resident #012's health record indicated that they experienced specified symptoms of infection for 18 days during the period of the home's Respiratory Outbreak mentioned above.

Review of resident #012's progress notes for the period mentioned above indicated that the resident's signs and symptoms of infection were not monitored on 15 occasions during specified days and shifts.

Review of resident #013's health record indicated that they experienced specified symptoms of infection for five days during the period of the home's Respiratory Outbreak mentioned above.

Review of resident #013's progress notes for the period mentioned above indicated that the resident's signs and symptoms of infection were not monitored on ten occasions during specified days and shifts.

Interview with RPN #109 revealed that they worked shift during the days and shifts specified above, and had failed to monitor and document, sign and symptoms of infection for the above mentioned residents.

ADOC #118 indicated that the home's expectation was that residents experiencing symptoms of infection should be monitored every shift, and documentation completed in their progress notes.

The ADOC further acknowledged that resident #004, #012, and #013 were line listed during the period mentioned above, and should have been monitored for symptoms of infection during day, evening and night shifts. [s. 229. (5) (a)]

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 on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 25th day of February, 2019

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

Original report signed by the inspector.