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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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5700, rue Yonge 5e étage
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Public Copy/Copie 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
Mar 11, 2021	2021_780699_0003	005535-20, 008731-20, 023519-20, 024211-20, 025806-20	Critical Incident System

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

PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 5, 8-12, 17-19, and 22, 2021.

The following Critical Incident System (CIS) intakes were inspected:

-Log 055806-20 [CIS 2837-000030-20], 023519-20 [CIS 2837-000026-20], 008731-20 [CIS 2837-000008-20], and 0055535-20 [CIS 2837-000005-20] related to staff to resident abuse; and
-log 023519-20 [CIS 2837-000028-20] related to unexpected death.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Medical Director, physicians, Coroner, Registered Dietitian (RD), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, reviewed internal investigation notes and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from neglect.

As per O. Reg. 79/10, s. 5, the definition of "neglect" means 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 home submitted a CIS report related to the unexpected death of a resident. The resident was provided their snack and was observed in distress shortly thereafter by a staff who was providing one to one monitoring. The staff alerted the RPN immediately, who attended to the resident. The RPN attempted to perform first aid. The resident subsequently became unconscious and passed away.

The licensee failed to ensure the resident was provided appropriate treatment for their medical emergency event. The resident was provided an incorrect textured snack. There was a period of time that the resident was still conscious where wholesome interventions were not provided. When the resident became unconscious there was no further attempt to address the medical emergency. There was no communication to the on-call physician until after the resident had passed away. The coroner stated that based on the information provided to them, there was no organized response to the event and that there was opportunity for education for staff related to what to do in emergency situations. The DOC indicated that if staff were not able to successfully do the first aid while the resident was in the wheelchair, staff should have brought the resident to the floor or against a hard surface. They would have expected the RPN to delegate someone to call the paramedics and code blue while they continued to try to assist the resident. The DOC and a physician indicated they would have expected staff to continue to perform first aid until the paramedics arrived, even if there was a specified health care wish in place.

Sources: Investigation notes, resident's clinical health record, progress notes, interviews with staff.

2. The licensee has failed to protect a resident from neglect.

The home submitted a CIS related to an incident of alleged staff to resident neglect. The resident reported that on two separate dates, they were left on the toilet for a period of time, despite repeatedly asking for assistance. The resident stated that they had repeatedly called for assistance to be taken off the toilet and they were in pain from being

seated so long. They also indicated they were not comfortable with being provided care by a staff member of a particular sex and voiced this concern to the staff who were assisting with the care. The staff proceeded to provide the resident care, despite their request for that staff member not to be present. Through the home's investigation, it was determined that there was neglect as the resident was left longer than they should have been on the toilet.

Sources: Investigation notes, the resident's clinical health record, interviews with the resident and staff members.

Additional Required Actions:

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

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care related to behaviour was followed.

The home submitted a CIS report related to alleged staff to resident abuse. Review of the resident's plan of care indicated that the resident exhibited responsive behaviours during care. An intervention in place for the resident's responsive behaviour was to leave the resident and re-approach in five to ten minutes. The PSW assisting the resident that day, found them to be soiled. They provided care to the resident even though the resident was exhibiting responsive behaviours. The PSW stated that the resident did not have altered skin integrity prior to care and this may have occurred when they were providing care to the resident. The PSW and the DOC acknowledged that the resident's plan of care was not followed.

Sources: Resident's care plan, interview with staff. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 the Infection Prevention and Control (IPAC) program.

The inspector made the following observations on a tour conducted in the home:
-Observed a staff member enter a room, with no gown or gloves on, approached the resident, less than six feet away. Noted contact/droplet precaution sign on resident door;
-observed a staff member enter a resident room with a meal tray, wore gown, but no gloves. They repositioned the resident, and opened food packaging. -observed the staff member doff gown, and left room without completing hand hygiene;
-observed a staff member in a resident's room, assisting the resident with a tray, gown on, no gloves on;
-observed several residents wandering on a unit, no masks on, no staff observed to be re-directing residents back to their rooms.

Staff indicated that the home was on outbreak and all residents were on contact/droplet precautions. Staff were expected to wear gown, gloves, surgical mask and face shield when entering resident rooms. Staff acknowledged that they did not wear the appropriate personal protective equipment (PPE) when they entered the resident rooms. Residents were expected to be redirected to their rooms, or to be wearing masks if found wandering around the unit.

Sources: Observations conducted on February 5 and 10, 2021, interviews with staff. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 16th day of March, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	PRAVEENA SITTAMPALAM (699)
Inspection No. / No de l’inspection :	2021_780699_0003
Log No. / No de registre :	005535-20, 008731-20, 023519-20, 024211-20, 025806-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 11, 2021
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Deerwood Creek Care Community 70 Humberline Drive, Etobicoke, ON, M9W-7H3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Carol Ois

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 2063414 Ontario Limited as General Partner of 2063414 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

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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will be compliant with s. 19 of the LTCHA.

Specifically, the home must:

1. Review and revise home's "Code Blue" policy to include a written protocol for the management of acute medical emergencies, including but not limited to choking. This protocol should include roles and responsibilities of staff. All registered staff must be trained on this revised policy, which must be made available at all nursing stations.
2. Ensure all registered staff are certified annually in cardiopulmonary resuscitation (CPR), as per the home's requirements.
3. Ensure that all direct care staff involved in resident #004's care are aware of the resident's plan of care prior to providing resident care.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from neglect.

As per O. Reg. 79/10, s. 5, the definition of "neglect" means 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 home submitted a CIS report related to the unexpected death of a resident. The resident was provided their snack and was observed in distress shortly thereafter by a staff who was providing one to one monitoring. The staff alerted the RPN immediately, who attended to the resident. The RPN attempted to perform first aid. The resident subsequently became unconscious and passed

away.

The licensee failed to ensure the resident was provided appropriate treatment for their medical emergency event. The resident was provided an incorrect textured snack. There was a period of time that the resident was still conscious where wholesome interventions were not provided. When the resident became unconscious there was no further attempt to address the medical emergency. There was no communication to the on-call physician until after the resident had passed away. The coroner stated that based on the information provided to them, there was no organized response to the event and that there was opportunity for education for staff related to what to do in emergency situations. The DOC indicated that if staff were not able to successfully do the first aid while the resident was in the wheelchair, staff should have brought the resident to the floor or against a hard surface. They would have expected the RPN to delegate someone to call the paramedics and code blue while they continued to try to assist the resident. The DOC and a physician indicated they would have expected staff to continue to perform first aid until the paramedics arrived, even if there was a specified health care wish in place.

Sources: Investigation notes, resident's clinical health record, progress notes, interviews with staff.

2. The licensee has failed to protect a resident from neglect.

The home submitted a CIS related to an incident of alleged staff to resident neglect. The resident reported that on two separate dates, they were left on the toilet for a period of time, despite repeatedly asking for assistance. The resident stated that they had repeatedly called for assistance to be taken off the toilet and they were in pain from being seated so long. They also indicated they were not comfortable with being provided care by a staff member of a particular sex and voiced this concern to the staff who were assisting with the care. The staff proceeded to provide the resident care, despite their request for that staff member not to be present. Through the home's investigation, it was determined that there was neglect as the resident was left longer than they should have been on the toilet.

Sources: Investigation notes, the resident's clinical health record, interviews with

the resident and staff members.

Severity: Resident #001 was not provided with appropriate interventions/care when they experienced an acute medical emergency, resulting in actual risk of harm. Resident #004 experienced pain from being seated on the toilet for an extended period of time, despite requesting for assistance, resulting in actual harm.
Scope: Two out of six residents reviewed experienced neglect, indicating an isolated incident.
Compliance History: 1 Compliance order (CO), 1 Voluntary Plan of Correction (VPC) were issued to the same subsection in the last 36 months. (699)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 28, 2021

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:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 11th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Praveena Sittampalam

Service Area Office /
Bureau régional de services : Toronto Service Area Office