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
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Aug 26, 2021	2021_780699_0015	004476-21, 008723-21, 012200-21	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), JOY IERACI (665)

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): August 11-13, 17-19, 2021

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

Log #008723-21 and #012200-21 related to fall with injury.

The following follow up intake was inspected:
Log # 004476-21 related to compliance order #001 from inspection #2021_780699_0003.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Infection Prevention and Control (IPAC) lead, Environmental Service Director, housekeeping aide, Registered nurse, Registered practical nurses, and personal support workers.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
3 VPC(s)
0 CO(s)
0 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. 19. (1)	CO #001	2021_780699_0003	699

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was safe and secure.

The inspector conducted observations of a meal service on three separate dates. Approximately two to four residents were seated at a table, less than six feet apart on three resident home areas. Staff were unaware of which residents were unvaccinated or partially vaccinated. Review of the seating charts showed that unvaccinated and partially vaccinated residents were seated together at one table, less than six feet apart. Staff confirmed that residents were not seated six feet apart from each other.

As per Directive #3, the home must ensure that physical distancing, a minimum of six feet, is practiced by all individuals, with specific exceptions. The public health investigator indicated that residents who were unvaccinated or partially vaccinated should maintain a distance of six feet.

Sources: Observations, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, seating charts, and interviews with staff. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

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 a fall intervention was provided to a resident as specified in the plan.

A Critical Incident System (CIS) was submitted to the Ministry of Long-term Care (MLTC) related to a resident sustaining a fall resulting in an injury.

The resident's care plan indicated that the resident required a specific fall interventions when seated in a mobility device or chair. Staff transferred the resident to the lounge chair and they did not transfer the fall intervention with the resident. The staff confirmed that the resident's plan of care was not followed.

Sources: Critical incident system report, resident's care plan, progress notes, home's investigation notes, and 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. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the interdisciplinary falls prevention and management program was implemented in the home.

A CIS was submitted to the MLTC related to a resident sustaining a fall resulting in an injury.

A resident was found on the floor and was attended by staff. Staff indicated that a full head to toe assessment was not conducted at the time of the fall, only a quick assessment to see if there was any immediate injury to the resident. A full head to toe assessment would have to occur in the resident room as they would have to check the resident's skin. Staff indicated that they could not complete a full head to toe assessment as the resident was exhibiting responsive behaviour, however was able to initiate head injury routine.

There was no completed post fall assessment documented on the day of the fall. For a period of three days, there was no documentation of the fall that occurred, no initiation of the 72 hour post fall monitoring, head injury routine or update to the care plan. There was no report of a fall in the 24 hour report. The staff that worked the following shifts after the fall were unaware the resident had sustained a fall and did not complete the head injury routine for the resident. There were no referrals to any interdisciplinary team members related to the fall.

The staff who attended the resident on the day of the fall, returned to work the floor and was notified that the resident was experiencing pain and difficulty weight bearing. Staff indicated that they did not see any documentation or communication related to the fall that occurred three days prior. The resident was subsequently sent out to the hospital for assessment.

As per the home's fall prevention and management policy, VII-G-30.10, last revised February 2020, after a resident has a fall, the nurse would initiate a head injury routine if a resident fall was unwitnessed, conduct a thorough investigation of the fall incident, complete a post fall, update a resident's plan of care, and complete referral to appropriate discipline. Additionally, the home's fall program included a post fall checklist which required 72 hour monitoring of the resident after a fall.

Staff acknowledged that the home's fall prevention and management program was not implemented for the resident.

Sources: Record review of resident's clinical health record, progress notes, post fall assessment, care plan with full revision history, the home's investigation notes, and interviews with staff. [s. 48. (1) 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 the falls prevention and management program to reduce the incidence of falls and the risk of injury is implemented in the home, to be implemented voluntarily.

Issued on this 27th day of August, 2021

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

Original report signed by the inspector.