Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 25, 2023	
Inspection Number: 2022-1322-0002	
Inspection Type: Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Deerwood Creek Care Community, Etobicoke	
Lead Inspector Helina Leung (741076)	**Inspector Digital Signature**
Additional Inspector(s) Nicole Ranger (189)	

INSPECTION SUMMARY

The Inspection occurred on the following dates:
December 13, 15, 16, 19, 20 and 21, 2022

The following intakes were inspected:

- Intake: #00008117 - [CIS: 2837-000041-22] Unwitnessed fall of resident resulting in injury
- Intake: #00010866 - [CIS:2837-000048-22] Potential improper transferring and positioning of resident by staff resulting injury
- Intake: #00012603 - [CIS: 2837-000052-22] - Resident sustained injury with unknown cause

The following intakes were completed:

- Intake: #00002735 - [CIS: 2837-000022-22] Fall of resident resulting in injury
- Intake: #00004765 - [CIS: 2837-000021-22] Fall of resident resulting in injury
- Intake: #00004775 - [CIS: 2837-000031-22] Fall of resident resulting in injury
- Intake: #00006384 - [CIS: 2837-000037-22] Unwitnessed fall of resident resulting in injury

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for transfers was provided to resident #001 as specified in the plan.

Rationale and Summary

On a specified date, a resident was found to have an injury for which the resident was taken to the hospital. The home's internal investigation was inconclusive related to the cause of the injury.

Resident #001's written care plan specified extensive assistance by one team member with transfers and toileting.

Two Personal Support Workers (PSW) reported using a specialized device with the resident on an identified date and acknowledged the care plan specified that the resident required extensive assistance by one person for a pivot transfer.

Another PSW and a Registered Practical Nurse (RPN) acknowledged that the specialized device was not specified in the resident's care plan.

The Director of Care (DOC) acknowledged that the two PSWs did not comply with the resident's care plan related to transfers when they used the specialized device.

There was risk of injury and triggering of the resident's behaviour when the staff transferred the resident with the specialized device, instead of a pivot transfer as specified in the plan of care.

Sources

Review of resident's care plan, progress notes, CIS report 2837-000052-22, home's investigation notes, and interviews with PSWs, RPN, and DOC.

[741076]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9)(b)

The licensee has failed to ensure that the symptoms indicating the presence of infections were recorded on every shift.

Rationale and Summary

A resident had an infection in December 2022 and documentation related to the presence of symptoms of infection was not recorded by staff on every shift.

During a review of the resident's records, the Assistant Director of Care (ADOC) acknowledged that staff were expected to document the symptoms indicating the presence of infection on every shift for the resident in December 2022.

Sources

Review of resident's progress notes and interview with ADOC.

[741076]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2)(b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff related to routine practices and additional precautions.

Rationale and Summary

At the time of the inspection, the following IPAC practices were observed:

1. Masking
The home's policy Masks, Eye Protection & Face Shields, IX-G-10.40 states that a mask must fit securely over the nose and mouth.

IPAC Standard for Long-Term Care Homes (April 2022), s. 9.1 (d) states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program to include proper use of PPE, including appropriate selection, application, and removal.

On an identified date, a PSW was observed wearing a cloth mask under a medical mask.
On an identified date, another PSW was observed wearing a medical mask with the loops twisted and worn around their ears.

ADOC (IPAC Lead delegate) acknowledged that twisting the loops and double masking are not acceptable practices in the home.

2. Face Shield
The home's Masks, Eye Protection & Face Shields, IX-G-10.40 policy states that cleaning products required for cleaning and disinfection of reusable eye protection are: soap (e.g. dish soap), sink or running water, and disinfectant wipes (eg. Accel wipes).

On an identified date, a housekeeper reported cleaning their face shield with soap and sometimes used alcohol-based hand rub (ABHR). The ADOC confirmed staff should use disinfectant wipes to disinfect face shields, after cleaning with soap and water.

There was risk of infection transmission to residents when staff were not wearing medical masks as required. There was a potential contamination risk when the housekeeper did not disinfect their face shield with disinfectant wipes.

Sources

Observations conducted on identified dates, review of the home's policy titled Masks, Eye Protection & Face Shields, IX-G-10.40 (Last Revised: 04/2022), IPAC Standard for Long-Term Care Homes (April 2022), and interviews with housekeeper and ADOC (IPAC Lead delegate).

[741076]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (7)11.

The licensee has failed to ensure that there was in place a hand hygiene program in accordance with any standard or protocol issued by the Director which includes, at a minimum, access to hand hygiene agents.

Rationale and Summary

IPAC Standard for Long-Term Care Homes (April 2022), s.10.1 states the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% alcohol-based hand rub (ABHR). These agents shall be easily accessible at both point-of-care and in other resident and common areas.

The home's policy Hand Hygiene, IX-G-10.10 states that Housekeeping Aides will make available paper towels, liquid hand soap, and ABHR for all team members and volunteers for hand hygiene.

On an identified date, a container of ABHR was found in the common area on the first floor with an expiration date of April 2022, and another container was used by a housekeeper with an expiration date of August 2022. The ADOC reported that the maintenance and housekeeping staff were responsible for checking the expiry dates for ABHR in the home.

There was risk of infection transmission to residents when expired ABHR was being used.

Sources

Observations conducted on an identified date, review of the home's policy titled Hand Hygiene, IX-G-10.10 (Last Revised 12/2021), IPAC Standard for Long-Term Care Homes (April 2022), and interview with ADOC (IPAC Lead delegate).

COMPLIANCE ORDER #001 TRANSFERRING AND POSITIONING TECHNIQUES

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Conduct random audits of staff provision of transferring assistance to residents on day and evening shift for a period of three weeks.
2. Maintain a record of audits completed, including but not limited to, date of audit, person completing the audit, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents #002 and #003.

Grounds

(i) On a specified date, PSW #104 assisted resident #002 with provision of care in bed in their room. The PSW left the bedside to obtain additional supplies. When the PSW returned, they found resident #002 on the floor and assessed the resident. X-ray taken revealed an injury. The resident was transferred to the hospital on a specified date and returned to the home on the same day. The resident passed away on a specified date. The cause of death was complications of fractures secondary to fall from bed.

PSW #104 stated that resident #002's plan of care required two staff members for transfers and personal care. PSW #104 reported that on a specified date, resident #002 required assistance with continence change. They provided care to the resident in bed, then left the resident's bedside to obtain additional supplies. When they returned, the resident had fallen from the bed and was found on the floor. PSW #104 reported that while they attempted to lift the resident up from the floor using a specialized device, PSW #108 entered the room and observed the resident on the floor. PSW #108 stopped PSW #104 with the transfer and went to alert RPN #107 of the incident. PSW #104 admitted that they did not use a second person to assist resident #002 with personal care and transfers.

ADOC #103 and DOC #101 acknowledged that PSW #104 did not use safe transferring and positioning techniques when they assisted resident #002 with care.

Failure to use safe transferring device and techniques by PSW #104 caused significant injury to the resident.

Sources: Resident #002's written plan of care, progress notes, home's investigation notes, CIS report #2837-000048-22, interviews with PSWs #104, #106, #108, RPN #107, ADOC #103, and DOC #101.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Grounds

(ii) On an identified date, Personal Support Worker (PSW) #110 assisted resident #003 to their room and provided care. Resident #003 has a history of falls and required falls interventions in place. PSW #110 implemented falls interventions. An hour later, PSW #109 heard the bed alarm ringing, went into the resident's room and found them lying on the floor. RPN #111 assessed the resident who was found with an injury. Resident #003 was transferred to the hospital on the same day. The resident returned to the home two days later, with the diagnosis of end of life care due to complications from the injury. The resident passed away approximately four weeks after the incident. The cause of death was complications related to the injury.

Resident #003 was high risk for falls and required fall interventions. PSW #109, RPN #112 and PSW# 110 reported that the resident's bed was usually placed in a particular position with the fall mattress on the floor.

PSW #109 reported that on an identified date, the bed was placed in a different position with the fall mattress on one side of the bed only. PSW #109 reported that they found the resident on the floor with injuries, and no fall mattress in place where it should have been. PSW #109 reported that they were unsure as to why the bed was not placed in the original position.

ADOC #103 and DOC #101 acknowledged that resident #003's bed was not in the correct position.

Failure to ensure that staff used safe bed positioning placed resident #003 at risk of injury.

Sources: Resident #003's written plan of care, progress notes, homes investigation notes, CIS report #2837-000041-22, interviews with PSW #109, PSW #110, RPN #111, RPN #112 ADOC #103, and DOC #101.

[189]

This order must be complied with by March 3, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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