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
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Original Public Report

Report Issue Date: April 13, 2023	
Inspection Number: 2023-1322-0003	
Inspection Type: Follow up 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 Wing-Yee Sun (708239)	**Inspector Digital Signature** Wing Yee Sun 2023.04.27 12:27:53 -04'00'
Additional Inspector(s) Nicole Ranger (189)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 17, 20-23, 2023

The following intake(s) were inspected:

- Intake: #00016116 - Potential improper care.
- Intake: #00017954 - Alleged physical abuse/neglect.
- Intake: #00018706 - Potential improper care.
- Intake: #00019782 - First Follow up to Compliance Order (CO) #001 under inspection #2022_1322_0002; related to O.Reg. 246/22, s. 40 - Transferring and positioning techniques

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1322-0002 related to O. Reg. 246/22, s. 40 inspected by Nicole Ranger (189)

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

Resident Care and Support Services
Continence Care
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: MEDICATIONS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 134 (2)

Non-compliance with s. 125 (2) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 (LTCHA) and s. 134 (2) of O. Reg. 246/22 under the Fixing Long-Term Care Act, 2021 (FLTCA).

The licensee has failed to comply with their Medication Reconciliation policy related to medication reconciliation.

On April 11, 2022, the FLTCA and O. Reg. 246/22 came into force, which repealed and replaced the LTCHA and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 125 (2) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 134 (2) of O. Reg. 246/22 under the FLTCA.

In accordance with O. Reg 79/10 s. 8 (1) (b) and O. Reg 246/22 s. 11 (1) (b) the licensee is required to ensure that the medication reconciliation process promoted the ease and accuracy of the administration of drugs to resident and support monitoring and drug verification activities.

Specifically, staff did not comply with the home's Medication reconciliation policy that directed staff compare the hospital readmission orders and hospital Medication Administration Record (MAR) to orders to previous MAR in the home, and to ensure MAR accurately reflects all new and changed orders.

Rationale and Summary

i) A resident was hospitalization for medical reasons. The resident was discharged home with an order for a medication change.

A Registered Practical Nurse (RPN) reported that they discovered another RPN had made a transcription error for the medication order, as the there was a discharge summary order and discharge prescription that was sent back with the resident. The RPN that discovered the error reported that the discharge summary orders stated to administer a higher dose than the discharge prescription had indicated. The RPN that transcribed the MAR used the higher dose. The RPN that discovered the error reported that the resident previously received a lower dose of the medication, which prompted the nurse to reviewed the hospital discharge summary orders and prescription. This RPN contacted the Physician (MD), and orders were received to administer the lower dose. The resident received the incorrect dosage for a number of days.

The Director of Care (DOC) stated that during the medication reconciliation process, the nurse was to review both the prescription and discharge orders with the MD, and the MD to make an informed decision on the correct dosage. The DOC acknowledge that staff did not follow the home's medication reconciliation process and policy related to accurate transcription of medication orders.

Failure to accurately verify and transcribe the medication orders, placed potential medical risk for the resident.

Sources: Review of the resident's MAR, home's investigation notes, hospital reports, medication incident form, CIS report, interviews with a RPN and the DOC.

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Rationale and Summary

ii) A resident had a medical history and experienced a change in their health status that required hospitalization. The resident had a specific medical diagnosis and was started on a specific medication. The resident was discharged to the home, with orders to discontinue the specific medication in a number of days, however the resident continued to receive the medication for a much longer period, when it was discovered by a RPN that the medication was to be discontinued. The Physician (MD) was contacted, and the medication started to be tapered off and discontinued eventually after it was discovered.

A RPN reported that when the resident was re-admitted back to the home, they completed the medication reconciliation process by reviewing the hospital discharge prescription to the MAR prior to hospitalization. During the process, they reported that they did not check the date of when the specific medication was to be discontinued and transcribed the order on the MAR to be given as a standing order. The RPN acknowledged that the specific medication order did not accurately reflect the orders received from the hospital.

The home's medication reconciliation process directs a second nurse to review the new MAR by comparing the hospital discharge summary and prescription, to verify the accuracy of the medication reconciliation.

The RPN, who was the second nurse, acknowledge that they did not verify the hospital discharge prescription to the new MAR, and stated that they just signed off on what the first RPN had written on the MAR.

The DOC acknowledge that staff did not follow the home's medication reconciliation process and policy related to accurate transcription of medication orders.

Failure to accurately verify and transcribe the medication orders, placed potential medical risk for the resident.

Sources: Review of the resident's MAR, home's investigation notes, hospital reports, medication incident form, CIS report, interviews with RPNs and the DOC.

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WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

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

Rationale and Summary

The home's policy for the use of transfer devices and transfers required two qualified team members to be present at all times when operating the device.

The resident used mobility and transfer devices. A Personal Support Worker (PSW) reported that the resident's family member requested care to be provided to the resident. The PSW reported that they had transferred the resident with a transfer device, with the family member assisting. The PSW acknowledge that the family member should not be used for the transfer, and they should have used a second team member, who was qualified, to assist with the transfers.

The DOC acknowledge that staff did not follow the home's policy of using a qualified second team member for transferring.

Failure to provide two qualified team members assisting with transferring placed the resident at risk of injury.

Sources: The resident's written plan of care, home's investigation notes, CIS report, review of home's policy titled Zero Lift & Protocol, IV-M-10.10, interviews with a PSW and the DOC.

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WRITTEN NOTIFICATION: CONTINENCE CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

The licensee has failed to ensure that a resident who required continence care had sufficient changes to remain clean, dry and comfortable.

Rationale and Summary

The resident's plan of care indicate the resident requires a level of assistance with continence care. A PSW reported that on a specified date, at the beginning of their shift, the resident had left their unit with their family to attend an event in another area. The PSW reported that the resident was off the unit for a number of hours, and once the resident returned to the floor, the family member requested the resident to be changed. The PSW reported that the resident was heavily soiled.

The PSW reported that the expectation was that they check residents at the start of their shift, and

acknowledged that they did not check or change the resident prior to leaving the floor, and while the resident attended the event.

The DOC acknowledged that the resident did not receive assistance to remain clean, dry and comfortable.

Failure to provide continence care has the potential to increase the risk of skin impairment for the resident.

Sources: The resident's written plan of care, home's investigation notes, CIS report, interviews with a PSW and the DOC.

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WRITTEN NOTIFICATION: NUTRITION CARE AND HYDRATION PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to comply with the process to initiate a dietary referral for a resident.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to ensure there are policies and procedures related to nutritional care and dietary services, and must be complied with.

Specifically, staff did not comply with the policy **"**Referral to Dietitian and/or Director of Dietary Services, VIII-D-10.10" last revised November 2019.

Rationale and Summary

The home's policy "Referral to Dietitian and/or Director of Dietary Services" directed registered staff to complete a dietary referral for specific diagnostic results.

The resident experienced a change in their medical condition requiring medication administration and transfer to the hospital. After the resident's return from the hospital, they were being monitored with a specific diagnostic tool for a number of days. On a number of occasions the diagnostic results indicated a dietary referral was required.

A RPN and a Registered Nurse (RN) acknowledged dietary referrals were not sent when the resident's diagnostic results indicated a dietary referral was required. The RN acknowledged that if the Registered Dietitian (RD) was consulted, they could assess if the resident required additional interventions.

The RD and the DOC acknowledged that registered staff failed to initiate a dietary referral as indicated in the home's policy.

The resident was at an increased risk of experiencing negative outcome related to the diagnostic results by not involving the RD as required.

Sources: CIS report, the resident's clinical file, home's policy "Referral to Dietitian and/or Director of Dietary Services, VIII-D-10.10" last revised November 2019, interviews with the RD, DOC and other staff.

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