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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 26, 2023	
Original Report Issue Date: August 25, 2023	
Inspection Number: 2023-1322-0004 (A1)	
Inspection Type: Critical Incident	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Deerwood Creek Care Community,Etobicoke	
Amended By Yannis Wong (000707)	**Inspector who Amended Digital Signature** Yannis Wong Digitally signed by Yannis Wong Date: 2023.09.26 15:06:17 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

- Extend the compliance order's compliance due date to October 20, 2023

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Lead Inspector Yannis Wong (000707)	**Additional Inspector(s)** Susan Semeredy (501)
Amended By Yannis Wong (000707)	**Inspector who Amended Digital Signature** Yannis Wong Digitally signed by Yannis Wong Date: 2023.09.26 15:05:57 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

- Extend the compliance order's compliance due date to October 20, 2023

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14-18, 2023

The following intake(s) were inspected:
Intake: #00092739 - [CI: 2837-000035-23] - Fall resulting in injury
Intake: #00091573 - [CI: 2837-000032-23] - Fall resulting in injury
Intake: #00093915 - [CI: 2837-000037-23] - Unknown cause of injury

The following intakes were completed in the Critical Incident System Inspection:
Intake: #00088201 - [CI: 2837-000023-23] - Fall resulting in injury
Intake: #00017940 - [CI: 2837-000002-23] - Fall resulting in injury
Intake: #00085523 - [CI: 2837-000017-23] - Fall resulting in injury
Intake: #00093014 - [CI: 2837-000036-23] - Fall 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

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.

The licensee has failed to ensure the plan of care included safety risks when a resident had two mobility aids in place.

Rationale and Summary
A resident was observed to have two mobility aids in place within close proximity to each other. There was an increased risk for entrapment of the resident between them. The safety risks were not included in the resident's plan of care. The Physiotherapist (PT) stated the resident should have enhanced monitoring and agreed the increased risk should be stated in the plan of care to inform all staff.

Failure to include the safety risks of entrapment in the resident's plan of care placed the resident at risk of injury.

Sources: Clinical records; observations; interview with PT

[000707]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that when a resident's care needs changed and care set out in the plan

was no longer necessary, the plan of care was reviewed and revised.

Rationale and Summary
A resident had falls with injuries. After the last fall the resident's care needs changed related to falls interventions. Observations and interviews indicated there were several interventions in their plan of care that had not been revised.
A Registered Nurse (RN) and Associate Director of Care (ADOC) confirmed that the resident's plan of care had not been reviewed and revised when the resident's care changed, and interventions were no longer necessary.

Failing to revise the resident's plan of care put the resident at risk for receiving care that did not adequately meet their current needs.

Sources: A resident's care plan including a history of revisions, interviews with staff and observations.

[501]

WRITTEN NOTIFICATION: Bed rails

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

The licensee has failed to ensure that where bed rails were used for a resident, the resident was assessed, and the resident's bed system was evaluated.

Rationale and Summary
Three residents had bed rails installed and in each case bed safety assessments have not been completed. The home's policy and interviews with the Physiotherapist and other staff indicated a bed safety assessment should be conducted after the bed rails have been installed.

Failing to assess a bed for safety after the installation of bed rails placed the residents at risk for entrapment and injury.

Sources: Residents' clinical records including assessments, the home's policy titled Bed Rails, VII-E-10.30 last revised April 2019 and interviews with the PT and other staff.

[501] [000707]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument after a resident sustained a fall.

Rationale and Summary
A resident had an unwitnessed fall. An Registered Practical Nurse (RPN) checked the resident for signs of injury and monitored them during the shift. A post-fall assessment was not completed. An ADOC confirmed a post-fall assessment with a clinically appropriate tool was not completed for the resident as per the home's policy.

Failure to complete a post-fall assessment could result in a delay in identifying potential fall prevention strategies for the resident.

Sources: Resident's clinical record, the home's policy titled Falls Prevention & Management, VII-G-30.10 last revised April 2023, and interviews with RPN and ADOC.

[000707]

COMPLIANCE ORDER CO #001 Compliance with manufacturers' instructions

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Immediately audit all specific bedside mobility aids in the home to ensure there is a safe distance between the mobility aid and the bed, consistent with manufacturers' instructions.
2. Maintain a record of audits; including resident room and bed number, who conducted the audit, time and date, results of each audit, and actions taken in response to the audit.
3. Develop a written process to ensure the manufacturers' instructions for the mobility aid placement

are followed and maintained for a safe distance between each bedside mobility aid and resident bed.
4. Conduct training for all nursing and housekeeping staff on the entrapment risk of the bedside mobility aid, and how to identify and maintain a safe distance between the bedside mobility aid and bed for all residents with the mobility aid.
5. Maintain a record of training; including who attended the training, time and date, who conducted the training, topics covered in the training.

Grounds
The licensee has failed to ensure that the use of a resident's mobility aid was in accordance with manufacturers' instructions.

Rationale and Summary
A resident was found entrapped between their bedside mobility aid and their bed.

The manufacturers' instructions state that specified mobility aids placed in the bedroom should be as close to the bed as possible. The instructions also contain a warning for potential risk for entrapment. The Director of Environmental Services conducts monthly audits to ensure mobility aids in the home are in good repair but does not measure the distance between the bedside mobility aid and the bed during the audits.

The home did not have a copy of the manufacturers' instructions prior to the inspection. The Director of Environmental Services was not familiar with the instructions. After reviewing the instructions, they acknowledged that the mobility aid poses an entrapment risk and referenced the entrapment incident with the resident, where the distance between the bed and mobility aid would have been larger than the instructions.

Failure to follow the manufacturers' instructions for usage of mobility aid resulted in the resident's entrapment incident and risk for serious injury.

Sources: Interviews with staff; resident's clinical records; and manufacturers' instructions

[000707]

This order must be complied with by October 20, 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.