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: March 5, 2024
Inspection Number: 2024-1322-0001
Inspection Type: Complaint Critical Incident Follow up
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Deerwood Creek Community, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2024.03.18 12:32:21 -04'00'

Additional Inspector(s)
Slavica Vucko (210)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 30, 31, 2024 and February 1, 2, 5, 7, 8, 9, 12, 2024

The following intake(s) were inspected:

- Intake: #00104875 - Critical Incident System (CIS) #2837-000060-23 - related to fall prevention
- Intake: #00104222 - Follow up related to Transferring and positioning
- Intake: #00107511 - CIS #2837-000005-24 - related to Outbreak Management
- Intake: #00104983 - Complaint related to maintenance services and recreational activities
- Intake: #00106737 - Complaint related to resident rights

The following intakes were completed during this inspection:

- Intake: #00105730- CIS #2837-000002-24; Intake #00099002- CIS #2837-000043-23 related to fall prevention
- Intake: #00104644/CIS #2837-000057-23, Intake #00107684-24/ CIS #2837-000006-24 related to Outbreak Management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1322-0005 related to O. Reg. 246/22, s. 40 inspected by Slavica Vucko (210)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Residents' Rights and Choices
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee has failed ensure that a policy directive that applied to the long-term care home, was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were required to ensure that the Infection Prevention and Control (IPAC) audits set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", was followed.

The guidance document stated long-term care homes must complete IPAC audits quarterly unless in outbreak. When a long-term care home is in outbreak, the audits must be completed weekly. At minimum, the audits must include Public Health Ontario's "COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes".

Rationale and Summary
The home was in an outbreak from November 20 to December 27, 2023. An IPAC audit was not completed during the week of December 12, 2023. Additionally, the home was in an outbreak from December 19 2023 to January 12, 2024. An IPAC audit was not completed during the weeks of January 1 and January 8, 2024.

The IPAC Lead acknowledged that there were missing IPAC audits for the above dates.

Failure to conduct IPAC audits at the required interval increased the risk of ineffective outbreak management.

Sources: Home's IPAC audit records, CIS #2837-000057-23, Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes, COVID-19 Guidance Document for Long-Term Care Homes in Ontario updated November 7, 2023, and interview with the IPAC Lead #102.

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WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

The licensee has failed to comply with their Water Temperature Monitoring policy related to recording of water temperatures.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have

procedures to ensure that the temperature of the water serving all bathtubs, showers and bathrooms used by residents did not exceed 49 degrees Celsius, and be complied with.

Rationale and Summary:
Specifically, staff did not comply with the home's policy titled "Water Temperature Monitoring", that directed staff to perform water temperature checks for random resident bathrooms and tub rooms on each shift and record the water temperature on the Water Temperature Monitoring record.

A resident reported to the inspector that the water coming out of the hot water tap was cold. The inspector reviewed the water temperature record for the unit for an identified time period and noted that the hot water temperatures were not measured consistently on every shift.

A Personal Support Worker (PSW) stated that the water temperature in the resident rooms was required to be taken in the morning prior to giving residents a shower. The PSW stated that the resident was scheduled to receive water temperature check taken that same day and acknowledged they did not take the water temperature.

The Director of Care (DOC) and a Registered Practical Nurse (RPN) both stated that it was the responsibility of the PSWs to measure the water temperature on each shift. Both the DOC and the RPN acknowledged that the water temperatures were not completed consistently on every shift.

Staff's failure to measure the temperature of water serving the resident's bathroom may put residents at risk for injury related to extreme water temperatures.

Sources: the home's policy "Water Temperature Monitoring (VII-H-10.50), Last

reviewed April 2019), Water Temperature Logs; Interviews with resident #004, PSW #105, RPN # 119 and the DOC.

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WRITTEN NOTIFICATION: INFEECTION PREVENTION AND CONTROL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program related to Personal Protective Equipment (PPE use.

The licensee has failed to ensure that the infection prevention and control program required under subsection 23 (1) of the Act complies with the requirements of this section: all staff participate in the implementation of the infection prevention and control program.

Rationale and Summary
(a) The home was in an outbreak on an identified unit at the time of inspection. The PPE requirement for staff and visitors on the unit were a N95 mask and a face shield.

A PSW was observed inside a resident room wearing a surgical mask and without a face shield. Both residents in the room were on droplet and contact precaution, and the signage on the door indicated that gown, gloves, mask, and face shield were required to enter. The PSW acknowledged they should have worn the required PPE on the unit, and to also enter the room with residents on droplet and contact precautions.

The IPAC lead verified that staff were required to follow PPE requirement signage posted on the doors of resident rooms on additional precautions. They also indicated that staff were to wear N95 mask and face shield while on the unit. The IPAC Lead also confirmed that the staff were not following PPE requirements for the outbreak unit.

Failure of staff to adhere with PPE requirements when interacting with residents on additional precautions and as required for outbreak units increased the risk of transmission of infection.

Sources: Observations on an identified date; interviews with PSW #105, IPAC lead #102 and other relevant staff.

(b) The home was in an outbreak on an identified unit at the time of inspection. The PPE requirement for staff and visitors based on public health recommendations for the unit required a surgical mask and a face shield to be worn. A security guard seated outside a resident's room was observed wearing a surgical mask without a face shield. A RPN and a PSW were also observed wearing only a surgical mask. The RPN stated that the unit was on outbreak and PPE requirements were a surgical mask and face shield. The RPN acknowledged they were aware of the face shield requirement for the unit and that the staff observed did not wear the required PPE.

On the same day, a PSW student was observed entering the unit wearing a surgical mask only.

The IPAC lead verified that staff were to wear a surgical mask and face shield while on the unit. The IPAC Lead also confirmed that the staff were not following PPE requirements for the outbreak unit.

Failure of staff to adhere with PPE requirements as required for outbreak units increased the risk of transmission of infection.

Sources: Observations on an identified date; interviews PSW student # 121, RPNs #107, IPAC lead #102 and other relevant staff.

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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 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored and recorded.

IPAC Standard for Long-Term Care Homes (revised September 2023), s. 3.1 (b)

states the licensee shall ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary
The home was in an outbreak during an identified time period.

The home required staff to monitor symptoms indicating the presence of infections every shift on the unit for the affected residents.

The public health line listing identified the onset of first symptoms for three residents was on identified dates. All residents were placed on additional precautions accordingly.

Record review of the residents' progress notes showed that symptoms indicating the presence of infections were not documented every shift.

The IPAC Lead and the DOC both indicated that symptoms indicating the presence of infections should have been monitored every shift and documented in the residents' progress notes. The IPAC Lead acknowledged that there was missing monitoring documentation for identified residents.

There was a moderate risk when the home did not document symptoms indicating the presence of infections every shift.

Sources: CIS #2837-000057-23, Review of resident #001, #002, #003's progress notes, review of the public health line listing; interview with IPAC Lead #102 and the DOC.

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WRITTEN NOTIFICATION: REPORTING OF CRITICAL INCIDENTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed about an outbreak of a disease of public health significance or communicable disease.

Rationale and Summary

The home went into an outbreak as declared by the Public Health Unit (PHU) on January 24, 2024. The Critical Incident Report (CIS) indicated the outbreak was declared on January 24, 2024 at 1630 hours, however the report was first submitted to the Ministry of Long-Term Care on January 25, 2024 at 1110 hours.

The IPAC Lead acknowledged that the outbreak was declared on January 24, 2024, and was not immediately reported to the Ministry of Long-Term Care.

There was low risk to the residents as the home had initiated outbreak measures as directed by the PHU.

Sources: Critical Incident Report #2837-000005-24, interview with Infection Prevention and Control (IPAC) Lead # 102.

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