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

Original Public Report

Report Issue Date: May 1, 2024

Inspection Number: 2024-1322-0002

Inspection Type:
Complaint
Critical Incident

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**
Noreen Frederick (704758)	Noreen Frederick Digitally signed by Noreen Frederick Date: 2024.05.23 15:12:05 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 26, 27, 28, 2024 and April 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 2024

The following intake(s) were inspected:

- Intake: #00104592 - [Critical Incident (CI): 2837-000055-23] - unknown etiology fracture
- Intake: #00106069 - [CI: 2837-000003-24] - Physical Abuse resulting in a fall with fracture
- Intake: #00112677 - Complaint related water temperature

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

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

Rationale and Summary
The resident's care plan indicated that they required an intervention due to the risk for falls. The Personal Support Worker (PSW) stated that they did not apply this intervention. Assistant Director of Care (ADOC) stated that staff were expected to provide the resident with this intervention as specified in their care plan.

Failure to ensure that a resident was provided with an intervention as specified in

their care plan, placed the resident at risk for a fall with potential injury.

Sources: resident's care plan, and interviews with the PSW and ADOC.

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WRITTEN NOTIFICATION: Obstruction, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 153 (b)
Obstruction, etc.
s. 153. Every person is guilty of an offence who,
(b) destroys or alters a record or other thing that has been demanded under clause 150 (1) (c);

The licensee has failed to ensure that staff members do not alter a record or other thing that has been demanded by the inspector conducting an inspection.

Rationale and Summary
The inspector reviewed the home's April 2024 "Resident Care Area Water Temperatures" forms for five home areas on April 10, 2024, and noted several missing water temperature logs. During an interview with Director of Environmental Services on April 11, 2024, it was discovered that "Resident Care Area Water Temperatures" forms for three home areas were altered and all missing entries of water temperatures were filled in. Upon further review and discussion with Director of Environmental Services, they acknowledged that the staff has altered the forms.

Deliberate falsification of documents obstructed the inspector from carrying out the inspector's duties.

Sources: Resident Care Area Water Temperatures forms, and interviews with Director of Environmental Services.

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WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and resident response to interventions were documented.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report related to a resident having an injury of unknown etiology. The resident's clinical records revealed that there was no documentation related to this incident, The PSW stated that during their shift, they observed the resident calling out in pain. They reported this to the Registered Practical Nurse (RPN) immediately. The RPN stated that they completed a physical and pain assessments for the resident and gave them pain medication however, they did not document their assessments and actions.

The ADOC stated that the RPN was expected to document their assessment of the

resident and interventions which they implemented.

Failure to ensure that a resident's assessment and actions taken were documented, placed the resident at increased risk of not receiving further re-assessment and interventions.

Sources: resident's clinical records, and interviews with the PSW , RPN and ADOC.

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WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program to identify and manage pain was implemented for a resident.

In accordance with O. Reg 246/22, 11 (1) (b), the licensee is required to ensure a pain management program to identify and manage pain is implemented and is complied with.

Specifically, the home did not comply with their policy "Pain & Symptom Management, VII-G-30.30".

Rationale and Summary

A resident was exhibiting pain for three days. Review of Point of Care (POC) revealed that the PSWs documented that the resident did not voice or show signs of pain. According to the home's pain and symptom management policy, " Recognize and report on a daily basis any resident verbalizations and behaviours indicative of discomfort and document electronically in POC/flow sheet". PSW #106, #107 and #108 all acknowledged that they observed the resident exhibiting signs of pain however, they did not document in POC. Same policy stated, "Monitor and evaluate effectiveness of pain medications in relieving resident's pain using pain scale in the vitals section of the electronic documentation system". The RPN stated that they did not document the effectiveness of the pain medication using pain scale in the vital section.

The ADOC acknowledged that the home's policy was not complied with and the PSWs were expected to document the resident's pain in POC and the RPN was expected to document pain scale in vital section for the effectiveness of the pain medication administered.

Failure to document pain, increased the risk of the resident not receiving the necessary interventions to manage their pain.

Sources: resident's clinical records, policy VII-G-30.30, "Pain & Symptom Management" last revised 03/2024 and interviews with PSW #106, #107, #108, RPN, and ADOC.

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WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, the resident was assessed.

In accordance with O. Reg 246/22, 11 (1) (b), the Long-Term Care Homes (LTCH) 's Falls Prevention & Management policy which was included in the LTCH's Falls Prevention and Management program was complied with when resident #003 fell and sustained a right femur fracture.

Rationale and Summary
A resident had an unwitnessed fall with an injury. The home's policy VII-G-30.10 "Falls Prevention & Management" last revised 04/2023, stated "Ensure the resident is not moved before the completion of a preliminary assessment", "Ensure resident is not moved if there is suspicion or evidence of injury" and "Mobilize the resident, ensuring that the appropriate lifting procedure". The RPN stated that they did not complete a post fall assessment until after the resident was manually lifted by staff. They confirmed that the resident was calling out due to pain when they fell.

The ADOC acknowledged that registered staff were expected to complete a post fall assessment when the resident was on the floor and prior to moving the resident.

Failing to comply with the LTCH's policy put the resident at risk for delayed identification of changes to the resident's health status following a fall.

Sources: resident's clinical records, LTCH's policy VII-G-30.10 "Falls Prevention & Management", last revised 04/2023, and interviews with the RPN, and ADOC.

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WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee has failed to ensure that strategies to manage the pain, including non-pharmacologic interventions were implemented and complied with for a resident.

Rationale and Summary
A resident was observed exhibiting signs of pain by PSW #106 and #107 on two days. Both PSWs reported this to RPN #103 and #104. Review of Electronic Medication Administration Record (EMAR) revealed that no pain medication was administered to the resident. Review of clinical records revealed no documentation of non-pharmacological interventions. RPNs #103 acknowledged that they did receive report from PSW #106 that the resident was in pain however, they did not

assess the resident and did not implement any strategies pharmacological or non-pharmacological to relive the resident's pain. RPN#104 acknowledged that they worked both days when the resident exhibited pain and were aware that the resident was experiencing pain as reported by the previous shift. They did not assess the resident for pain.

The ADOC stated that the staff were expected to treat the resident's pain using pharmacological as well as non-pharmacological interventions..

Failure to treat the resident's pain caused the resident unnecessary distress and discomfort.

Sources: resident's clinical records, and interviews with PSW #106, #107, RPN #103, #104 and ADOC.

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WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The Licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

Rationale and Summary
A resident exhibited signs and symptoms of pain. The PSW stated that they observed the resident in pain and reported this to the RPN who instructed the PSW to apply an ointment to the pain site. The RPN acknowledged that they gave this direction to the PSW, and they were aware that there was no physician's order for this medication which was confirmed by the resident's Electronic Treatment Administration Record (ETAR). The ADOC stated that staff were not to administer the ointment without a physician's order.

Administering a drug to the resident which was not prescribed for them, placed them at risk for potential side effects.

Sources: resident's clinical records, and interviews with the PSW, RPN and ADOC.

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WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that pain medication was administered to a resident in accordance with the directions specified by the prescriber.

Rationale and Summary
A resident was transferred to the hospital due to an unknown injury. The resident was prescribed an analgesic for five days upon their return from the hospital. Review of EMAR revealed that the resident did not receive 14 doses of this analgesic and the RPN acknowledged the same. The ADOC stated that staff were expected to administer pain medication to the resident in accordance with the directions specified by the prescriber.

Failure of staff to administer pain medication to the resident as prescribed, put them at risk of their pain not being managed.

Sources: resident's EMAR and hospital discharge physician orders, and interviews with the RPN and ADOC.

[704758]

COMPLIANCE ORDER CO #001 Maintenance services

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Conduct daily audits for a period of two weeks of the monitoring and documentation of water temperatures on each home area to ensure the water temperatures are maintained at a maximum of 49 degrees Celsius.

2. The home must maintain a record of the above audits, including the date, content, who completed the audit, and any corrective actions.

Grounds
The licensee had failed to ensure that the water serving all bathtubs and showers used by residents did not exceed a temperature of 49 degrees Celsius.

Rationale and Summary
Inspector reviewed Long-Term Care Home's (LTCH) "Resident Care Area Water Temperatures" forms for the period of March 1-31, 2024 and April 1- 9, 2024 and noted that the water temperature exceeded 49 degrees Celsius on 41 instances and was as high as 63.4 degrees Celsius. Director of Environmental Services acknowledged the same.

By not ensuring water temperatures were kept below the required 49 degrees Celsius, there was risk to residents' safety as they could sustain burns to their skin, pain and further injuries.

Sources: resident Care Area Water Temperatures from March 1-31, 2024, and April 1-9, 2024, and interview with Director of Environmental Services.

[704758]

This order must be complied with by June 7, 2024

COMPLIANCE ORDER CO #002 Maintenance services

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (h)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

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

The licensee shall:

1. Conduct daily audits for a period of two weeks on each home area to ensure when the water temperature exceeds 49 degrees Celsius, immediate actions are taken to reduce the water temperature.

2. The home must maintain a record of the above audits, including the date, content, who completed the audit, and any immediate actions taken when the water temperature exceeded 49 degrees Celsius.

Grounds
The licensee has failed to ensure that immediate action was taken to reduce the water temperature when it exceeded 49 degrees Celsius.

Rationale and Summary
Inspector reviewed Long-Term Care Home's (LTCH) "Resident Care Area Water Temperatures" forms for the period of March 1-31, 2024 and April 1-9, 2024, and noted that the water temperature exceeded 49 degrees Celsius on 41 instances. Director of Environmental Services acknowledged that 22 out of the 41 instances, no immediate actions were taken to reduce the water temperatures.

By not ensuring that immediate action was taken each time when the water temperature exceeded 49 degrees Celsius, there was risk to residents' safety as they can sustain burns to their skin, pain and further injuries.

Sources: resident Care Area Water Temperatures from March 1-31, 2024, to April 1-9, 2024, and interview with Director of Environmental Services.

[704758]

This order must be complied with by June 7, 2024

COMPLIANCE ORDER CO #003 Maintenance services

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (i)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

The inspector is ordering the licensee to comply with a Compliance

Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Conduct daily audits for a period of two weeks of the monitoring and documentation of water temperatures for resident bath/showers on each home area to ensure the water temperatures are maintained at a minimum of 40 degrees Celsius.

2. The home must maintain a record of the above audits, including the date, content, who completed the audit, and any corrective actions.

Grounds
The licensee has failed to ensure that the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Rationale and Summary
Inspector reviewed Long-Term Care Home's (LTCH) "Resident Care Area Water Temperatures" forms for the period of March 1-31, 2024, and April 1-9, 2024, and noted that the water temperatures in the bathtubs and showers were only monitored and documented one day a month. As per Director of Care (DOC), bathtubs and showers are used daily by the residents and each home area has total of approximately 8 to 10 showers/baths scheduled daily. Further review of the water temperature revealed that on 96 instances the water temperature was below 40 degrees Celsius and was as low as 22.1 degrees Celsius in residents' rooms and sinks. On April 6, 2024, one of the shower room temperatures was 22.5 degrees Celsius with no actions taken and on March 17, 2024, shower room temperature was missed.

Director of Environmental Services acknowledged the recorded instances of water temperatures below 40 degrees Celsius including 31 out of the 96 instances, in which no actions were taken as well as the instance of missing water temperature. The LTCH's policy, "Water Temperature Monitoring" VII-H-10.50, stated "Implement corrective actions (may include calling a contracted service provider if community team unable to fix the problem) when the water temperature is below 40˚ Celsius". Additionally, LTCH received a complaint on March 28, 2024, related to shower not being provided to a resident due to cold water in the shower room. Upon further review of the complaint, it was noted that the staff did not monitor the water temperature when the water was reported to be cold in the shower room.

By not ensuring water temperatures were kept between 40 and 49 degrees Celsius, residents were placed at risk of not receiving or being delayed in receiving their bath/shower and/or being bathed/showered in cold water.

Sources: resident Care Area Water Temperatures from March 1-31, 2024 and April 1-9, 2024, home's complaint record, LTCH's policy "Water Temperature Monitoring, VII-H-10.50", last revised 03/2024, email from ADOC #110, and interview with Director of Environmental Services.

[704758]

This order must be complied with by June 7, 2024

COMPLIANCE ORDER CO #004 Maintenance services

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)

Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

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

The licensee shall:

1. Ensure water temperatures are monitored and documented daily on each shift on all home areas.

2. Conduct daily audits for a period of two weeks of the monitoring and documentation of water temperatures on each home area to ensure it has been completed.

3. The home must maintain a record of the above audits, including the date, content, who completed the audit, and any corrective actions.

Grounds
The licensee has failed to ensure that the water temperatures were monitored once per shift in random locations where the residents have access to hot water.

Rationale and Summary
Ministry of Long-Term Care (MLTC) received a compliant related to the home not having hot water for bathing and showers of residents. Inspector reviewed Long-

Term Care Home's (LTCH) "Resident Care Area Water Temperatures" forms for the period of March1-31, 2024 and April 1- 9, 2024, and noted 87 missing documentations on several different days and shifts throughout the home. Director of Environmental Services acknowledged that staff were expected to monitor and document water temperatures once per shift.

By not ensuring that the water temperatures were monitored and documented once per shift, residents safety was put at risk by being exposed to water temperatures which fell outside of the required 40 to 49 degrees Celsius.

Sources: resident Care Area Water Temperatures from March 1-31, 2024 and April 1-9, 2024, and interviews with Director of Environmental Services and other staff.

[704758]

This order must be complied with by June 7, 2024

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.