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: September 4, 2024
Inspection Number: 2024-1322-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 2024

The following intake(s) were inspected:

- Intake: #00112459 - [Critical Incident (CI): 2837-000010-24] -Fall resulting in an injury
- Intake: #00115217 - Follow-up -Maintenance services
- Intake: #00115218 - Follow-up -Maintenance services
- Intake: #00115219 - Follow-up -Maintenance services
- Intake: #00115220 - Follow-up -Maintenance services
- Intake: #00120887 - [CI: 2837-000016-24] - Severe hypoglycemia
- Intake: #00121728 - Complaint related to improper care and falls
- Intake: #00121749 - [CI: 2837-000017-24] -Neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1322-0002 related to O. Reg. 246/22, s. 96 (2) (h) inspected by Noreen Frederick (704758)
Order #004 from Inspection #2024-1322-0002 related to O. Reg. 246/22, s. 96 (2) (k) inspected by Noreen Frederick (704758)
Order #001 from Inspection #2024-1322-0002 related to O. Reg. 246/22, s. 96 (2) (g) inspected by Noreen Frederick (704758)
Order #003 from Inspection #2024-1322-0002 related to O. Reg. 246/22, s. 96 (2) (i) inspected by Noreen Frederick (704758)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

The licensee failed to ensure that a resident's written plan of care set out the planned care.

Rationale & Summary:
A resident had multiple falls, and the post fall assessments stated a toileting schedule was in place prior for each fall. The care plan for the resident had no reference to a toileting schedule.

Registered Practical Nurse and Falls Lead acknowledged that the toileting schedule should have been included in the care plan for the resident.

Failure to provide a written planned care could have place the resident at an increased risk for falls.

Sources: Review of the resident's clinical record, and interviews with RPN and Falls Lead.

[000761]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different

aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of a resident's care collaborated with each other in the development and implementation of the plan of care.

Rationale & Summary:
Record review indicated that the Occupational Therapist (OT) recommended and notified the Director of Care (DOC) that a resident would benefit from specific fall prevention equipment.

The RPN, Falls Lead and OT confirmed that the resident did not receive recommended equipment.

Failure to provide recommended equipment, increased the risk of the resident's injury and of their needs not being met.

Sources: Review of the resident's clinical record and interviews with the RPN, Falls Lead and OT.

[000761]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that when the care set out in a resident's plan was not effective, different approaches were not considered in the revision of the plan of care.

Rationale and Summary:
(i) Record review indicated that a resident had multiple falls. Care plan indicated the resident should be closely monitored.

The RPN stated that the approach to closely monitor the resident was ineffective and different approaches could have been implemented. The RPN confirmed different approaches were not trialed for the resident. Falls Lead acknowledged that the care plan was not effective and different strategies should have been considered.

Failure to consider different approaches when the care plan has not been effective increased the risk of falls.

Sources: Review of the resident's clinical record and interviews with the RPN and Falls Lead.

Rationale and Summary:
(ii) Record review indicated that a resident attended a few programs.

Director of Resident Services (DRS) acknowledged that the resident attended fewer programs per month which was considered low participation, and other approaches should have been implemented to improve social engagement. They confirmed that the care plan should have been revised with different approaches to address the resident's low participation in activities.

Failure to consider different approaches for the resident increased the risk of social isolation.

Sources: Review of the resident's clinical record and interview with DRS .

[000761]

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected.

In accordance with the definition identified in section 7 of the Ontario Regulation 246/22 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
A resident was administered with insulin prior to breakfast. The resident was found with hypoglycemic symptoms in the afternoon. As a result, a therapeutic medication was administered and the resident was transferred to the hospital.

A Personal Support Worker (PSW) stated that the resident did not eat any breakfast or snack and was sleepy which was unusual for the resident. They reported this to an RPN. The RPN stated that they were aware that the resident did not eat any breakfast and snack and was sleepy however, they did not implement any interventions including blood glucose monitoring.

The Assistant Director of Care (ADOC) stated that the resident was at risk of hypoglycemia when the RPN administered the insulin and the resident did not eat breakfast and snack. They also acknowledged that the resident's health and safety was jeopardized when the RPN did not implement any monitoring including blood glucose level checks.

Due to inaction of the RPN when the resident did not eat after the administration of insulin, the resident's safety was jeopardized leading them to become hypoglycemic requiring further medical attention.

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

[704758]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Section 7.3, "the licensee shall ensure that the IPAC Lead plans, implements, and tracks the completion of all IPAC training and ensures that audits were performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role".

Rationale and Summary
Review of the Long-Term Care Home's (LTCH) Infection Prevention and Control (IPAC) audits revealed that specific IPAC practice audits were not conducted regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role. IPAC Lead acknowledged that the IPAC audits to ensure all employees were capable of carrying out the IPAC skills necessary for their roles were not completed.

Failure to conduct IPAC practice audits increased the risk of staff not adhering to appropriate infection control protocols, potentially leading to the spread of infectious diseases among residents and staff members.

Sources: LTCH's IPAC audits, interview with IPAC lead and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

[704758]

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