

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: November 5, 2024

Inspection Number: 2024-1322-0004

Inspection Type:

Critical Incident

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): October 22-25, and 29, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00124103/CI #2837-000018-24 was related to falls prevention and management.
- Intake: #00129434/CI #2837-000027-24 was related to injury to a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of a resident.

Rationale and Summary

A resident acquired injury while using a therapy device with a physiotherapist assistant (PTA). The resident had not used that device prior.

The PTA indicated that the the device hit the resident during exercise.

The Physiotherapist (PT) acknowledged that the device was not appropriate for the resident as they were not assessed for it.

Implementing an intervention for which the resident was not assessed resulted in injury to the resident.

Sources: Review of resident's clinical records; and interviews with PTA and PT.