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

Public Report

Report Issue Date: January 15, 2025

Inspection Number: 2025-1322-0001

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 on the following dates: January 6-9 and 13-15, 2025 were conducted on-site and January 10, 2025 was conducted off-site.

The following Critical Incident (CI) intakes were inspected:
-Intake #00133391 with CI #2837-000033-24 – was related to allegations of abuse.
-Intake #00131747 with CI #2837-000029-24 – was related to a fall incident.
-Intake #00131231 with CI #2837-000028-24 and Intake #00131938 with CI #2837-000030-24 – were related to disease outbreak.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
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:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the falls prevention and management procedure was implemented when a resident was transferred after their fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the falls prevention and management program were complied with. Specifically, the Long Term Care home's (LTCH) falls program indicated that the nurse was required to ensure that when mobilizing the resident that the appropriate lifting procedure was performed if no injury is evident, and observe for pain or difficulty weight bearing.

The personal support workers assisted the resident using inappropriate transfer techniques which resulted in them experiencing pain. The resident should have been transferred using a different technique until reassessed by the Physiotherapist (PT).

Sources: LTCH's Fall Program, LTCH's investigation notes, resident's clinical record, interviews with the LTCH's staff.

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
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:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that the skin and wound care program was implemented for a resident.

As per O. Reg 246/22, Sec. 11 (1) (b) the licensee was required to ensure that the Skin and Wound protocol was complied with. Specifically, the home's protocol indicated that the Nurse will respond to any skin and wound equipment related concerns and engage the interprofessional team to troubleshoot and determine corrective actions. The OT, PT or restorative care coordinator will assess the resident as required and advise on positioning and seating options.

A resident sustained an injury to their skin and had pain on an identified date. Tests were ordered. After a specified number of days, a referral was sent to the Physiotherapist for assessment because of a new injury and pain. The PT assessed, identifying that resident's assistive device was not functioning and recommended interventions. The PT also involved the Occupational Therapist (OT) for further assessments.

A referral to PT or OT for assessment of equipment and safety was not initiated for a specified number of days after the resident's altered skin integrity was identified.

Sources: LTCH's policy Skin and Wound Care, interviews with staff, review of clinical record, critical incident report.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On specified dates, there were several skin injuries documented in different places in the resident's clinical record, and it was not clear when they were obtained.

The home's expectation was for residents exhibiting altered skin integrity, the Nurses were to complete an electronic Skin & Wound Assessment form.

The Skin and Wound assessment was initiated on a specified date, but not when bruising first appeared.

Sources: Critical incident report, LTCH's policy Skin and Wound Care Protocol, interviews with staff, review of clinical record, observation.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that when a resident had altered skin integrity, they received immediate treatment and interventions to reduce or relieve pain.

On a specified date, a resident complained of pain during care. The pain was assessed on a specified date, by the Nurse Practitioner (NP) and a treatment was initiated.

The resident did not receive immediate treatment to relieve their pain when they reported it to staff.

Sources: Critical incident report, LTCH's policy Pain and Symptom Management, interview with staff, review of clinical record, observation.

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