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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Public Report

Report Issue Date: March 28, 2025
Inspection Number: 2025-1322-0002
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): March 13, 14, 18, 19, 25 - 28, 2025.

The following intake(s) were inspected:

- Intake: #00141047 Critical Incident (CI): #2837-000009-25 related to communicable disease outbreak.
- Intake: #00140665 CI: #2837-000008-25 related to alleged staff to resident abuse.
- Intake: #00137152 CI: #2837-000003-25 related to fall prevention and management.

The following intakes were completed in this CI inspection:

- Intakes: #00135568, #2837-000036-24; #00135561 CI 2837-000035-24 were related to fall prevention and management.
- Intakes: #00138455, CI #2837-000004-25; #00139761, CI #2837-000005-25; #00139987, CI #2837-000006-25 were related to communicable disease outbreaks.

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

Resident Care and Support 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 (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 for a resident was provided to the resident as specified in their plan.

A Registered Nurse (RN) implemented an intervention for a resident's safety and falls prevention. The Care Support Assistant (CSA) acknowledged that they did not follow the intervention and as a result the resident sustained a fall.

Sources: A resident's clinical records; interviews with a CSA and RN.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following

has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident immediately reported the suspicion and the information upon which it was based to the Director.

A resident reported an allegation of abuse that resulted in injury. The home failed to immediately report this incident to the Director.

Sources: A resident's clinical records; CI #2837-000008-25; and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a PSW used safe transferring techniques when they transferred a resident during their shift. The resident's care plan indicated a specific level of assistance was required for transfers, however a PSW performed the transfers without following the directions specified in the plan.

Sources: A resident's clinical records; and interviews with the PSW and DOC.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that a medication cart was locked. A medication cart was observed to be left unattended and unlocked on a residents home area. The Registered Practical Nurse (RPN) acknowledged the medication cart was to be locked at all times.

Sources: Observation; and interview with the RPN.