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: June 27, 2025

Inspection Number: 2025-1322-0003

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 23, 24, 25, 26, 27, 2025

The following intake(s) were inspected:

- Intake: #00142540 - Rhinovirus/Enterovirus Outbreak
- Intake: #00142897 - Enteric Outbreak
- Intake: #00144066 - Public complaint regarding resident care.
- Intake: #00144902 - Alleged improper care of 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

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care reflected the correct information regarding infection diagnoses. On a day in June, 2025, there was no additional precautions signage posted outside a resident's room. Upon reviewing a list of residents on additional precautions, the resident was not identified. The resident's diagnoses list included a diagnosis however, it was confirmed during an interview with the Infection Prevention and Control (IPAC) Lead that this diagnosis was added to the plan of care in error.

Sources: Observations made by Inspector, resident record review, review of a list of residents in the home requiring additional precautions, and an interview with IPAC Lead.

Date Remedy Implemented: June 25, 2025

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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).

A) The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 10.2 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that hand hygiene agent options, based on resident preference, adheres to the requirements under requirement 10.1 of the Standard.

Specifically, on a day in June, 2025, prior to lunch meal service, a staff was noted to be wetting disposable cloths with warm water, without using soap, to assist residents with hand hygiene.

In an interview with IPAC Lead, it was confirmed that the acceptable methods for hand hygiene in the home is with 70-90 % Alcohol Based Hand Rub (ABHR) or with soap.

Sources: Observations made by an Inspector and an interview with the IPAC Lead

B) The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with

additional requirement 9.1 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that hand hygiene was completed, including, but not limited to, the four moments of hand hygiene.

Specifically, on a day in June, 2025, a staff member went into a resident's room to complete medication administration, upon exiting the room, they went into the medication cart's locked box, and no hand hygiene was completed between these tasks. In another instance on a day in June, 2025, a staff member was in the dining room completing medication administration, and upon returning to the medication cart, they did not complete hand hygiene prior to touching items on the medication cart.

Sources: Observations made by an Inspector

C) The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 (f) for Additional Precautions under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal were followed in the IPAC program.

Specifically, on a day in June, 2025, an external staff member was observed completing a test for a resident in their room. Contact droplet signage was present at the entrance of the resident's room, as well as a PPE station that was stocked with supplies. The external staff was observed to not be wearing any PPE during their interaction with the resident. A list of residents in the home requiring additional precautions, provided by IPAC Lead, indicated that a resident required additional

precautions for a suspected respiratory infection at the time of their interaction with the external staff member.

Sources: Observations made by an Inspector and review of a list of residents in the home requiring additional precautions

D) The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 (e) for Additional Precautions under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that point-of-care signage indicating that enhanced IPAC control measures are in place was posted.

Specifically, on a day in June, 2025, it was observed that there was a PPE station outside a room; however, no signage for additional precautions was observed. At the time of this observation a staff identified that a resident, required additional precautions. A list of residents in the home requiring additional precautions, provided by IPAC Lead; as well as a review of resident's care plan related to IPAC, confirmed the requirement of additional precautions for a resident.

Sources: Observations made by Inspectors, review of resident's care plan, review of a list of residents in the home requiring additional precautions and an interview with staff.