

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: February 5, 2026

Inspection Number: 2026-1322-0001

Inspection Type:
Critical Incident

Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited

Long Term Care Home and City: Deerwood Creek Community, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29, 2026 and February 2-5, 2026 with January 30, 2026, conducted off-site.

The following intake were inspected in this Critical incident System (CIS) inspection:
- Intake: #00166649 - CIS #2837-000044-25 - Unknown cause of injury to a resident.
- Intake: #00166743 - CIS #2837-000003-26 - Improper care from staff resulting in injuries to a resident.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) 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.

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On two separate occasions with different residents and staff members,

1) A Personal Support Worker (PSW) assisted a resident with care provision and it was not in accordance to the resident's plan of care.

Sources: Resident care plan, home investigations notes and interviews with staff.

2) A PSW assisted a resident with care provision and it was not in accordance to the resident's plan of care.

Sources: Resident care plan, home investigation notes and interviews with staff.

WRITTEN NOTIFICATION: Duty To Protect

NC #002 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.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

A PSW used physical force while caring for a resident that caused and negative health outcome to the resident.

Sources: Interviews with staff, and home investigation notes.

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

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transferring and positioning devices or techniques when assisting residents.

A PSW performed an unsafe transfer when assisting a resident.

Sources: Resident care plan, home's investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Requirements Relating To The Use Of A PASD

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 120 (1)

Requirements relating to the use of a PASD

s. 120 (1) Every licensee of a long-term care home shall ensure that a PASD used under section 36 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained.

A resident's Personal Assistance Services Device (PASD) was not removed when it was no longer required.

Sources: Observations, interview with staff, the home's policy, and resident's clinical records.