

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

Toronto Service Area Office  
5700 Yonge Street 5th Floor  
TORONTO ON M2M 4K5  
Telephone: (416) 325-9660  
Facsimile: (416) 327-4486

Bureau régional de services de  
Toronto  
5700, rue Yonge 5e étage  
TORONTO ON M2M 4K5  
Téléphone: (416) 325-9660  
Télécopieur: (416) 327-4486

**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 6, 2020	2020_654618_0004	023591-19	Critical Incident System

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**Licensee/Titulaire de permis**

2063414 Ontario Limited as General Partner of 2063414 Investment LP  
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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**Long-Term Care Home/Foyer de soins de longue durée**

Deerwood Creek Care Community  
70 Humberline Drive ETOBICOKE ON M9W 7H3

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

CECILIA FULTON (618)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): January 23. 24, 2020.**

**This inspection was initiated to inspect issues identified in intake Log #023591-19, Critical Incident System Report (CIS) #2837-000038-19, related to resident hospitalization and significant change in condition.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Staff (RN/RPN), Personal Support Workers (PSW), and Physiotherapist (PT)**

**During the course of the inspection, the inspector reviewed pertinent resident and home records, observed residents and staff to resident interactions.**

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

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

- 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,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
  - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #001.

This inspection was initiated in response to a Critical Incident Report related to a significant change in resident #001's condition.

Review of the home's investigation file into this matter included many interviews with staff focusing on the provision of resident #001's care, particularly lifting and transferring.

The transcript of an interview conducted with PSW #100 identified that they provided care to resident #001 by themselves, including care performed while the resident was in their bed.

Review of resident #001's written plan of care identified the interventions and the level of assistance required for the provision of identified care including for bed mobility.

Interview with PSW #100 identified the level of assistance they would provide when performing the identified care. PSW #100 did not acknowledge that the identified care included bed mobility, and as a result they did not provide the level of care as required for tasks involving bed mobility.

Review of Physiotherapy assessments identified resident #001's required level of assistance for tasks involving bed mobility.

The PT confirmed that performing the identified tasks for resident #001, while they were in bed would involve bed mobility, and they confirmed the level of assistance that would be required.

Review of the written plan of care with the PT, and with ADOC confirmed that there is a lack of clear direction regarding the level of assistance needed to perform activities that involve bed mobility. [s. 6. (1) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident provides clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**Issued on this 7th day of February, 2020**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**