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

Original Public Report

Report Issue Date: December 14, 2023
Inspection Number: 2023-1322-0005
Inspection Type: Complaint Critical Incident Follow up
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Deerwood Creek Community, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Yannis Wong (000707)	Yannis Wong Digitally signed by Yannis Wong Date: 2023.12.21 10:58:27 -05'00'

Additional Inspector(s)
Joy Ieraci (665)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 22-23, 27-29 and December 1, 4-5, 2023.

The inspection occurred offsite on the following date(s): November 30 and December 6, 2023

The following intake was inspected in this Follow-up inspection:

- Intake: #00095479: Follow-up related to a previously issued High Priority Compliance Order (CO) #001 in 2023-1322-0004; Compliance with manufacturers' instructions

The following intakes were inspected in this Complaints inspection:

- Intake: #00101723 - Complaint related to improper care and medication administration
- Intake: #00102215 - Complaint related to improper transfer, pain management, and improper care

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00094218 [CI #2837-000038-23] - Alleged resident to resident physical abuse
- Intake: #00097558 [CI #2837-000041-23] - Alleged staff to resident financial abuse
- Intake: #00095695 [CI #2837-000040-23] - Disease outbreak
- Intake: #00102578 [CI #2837-000048-23] - Improper transfer and fall with injury

The following intake was completed in the CI inspection:

- Intake: #00098889 [CI #2837-000042-23] - Disease outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1322-0004 related to O. Reg. 246/22, s. 26 inspected by Yannis Wong (000707)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied: Plan of care

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 (10) (b)
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that resident #003's plan of care was revised when the care set out in the plan was no longer necessary.

Rationale and Summary

The resident had a history of responsive behaviours towards co-residents and was triggered when co-residents entered their room. The plan of care had devices to alert staff when co-residents entered the resident's room.

The resident's room did not have the devices on two separate observations, which was confirmed by Registered Nurse (RN) and Registered Practical Nurse (RPN).

The Behavioural Support Ontario (BSO) Lead indicated that the resident was assessed and the device was no longer necessary. The plan of care was revised by the BSO Lead after the interview.

There was no risk to the resident when the plan of care was not revised; however, staff would not have been provided clear directions in managing the resident's responsive behaviours.

Sources: Observations; review of resident's clinical records, and interviews with BSO Lead and other staff. [665]

Date Remedy Implemented: December 4, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Involvement of resident, etc.

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM), was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

The SDM of the resident indicated that they were not given the opportunity to make health care decisions when the resident had a change in health status and was transferred to hospital.

RPN notified another family member of the resident's change in status and received consent for the transfer to hospital. The family member came to the home and made health care decisions for the resident. RPN was not aware that the SDM should have been notified of the resident's change in status and consent for any health care decisions until after the resident was already transferred to hospital.

The Director of Care (DOC) indicated that the SDM was the primary contact for health care decisions for the resident.

Failure to have the SDM participate fully in the resident's development and

implementation of the plan of care, may have impacted the resident's ability to receive support for their emotional well being and their quality of life from their SDM.

Sources: Review of resident's clinical records and home's investigation notes, and interviews with the SDM, RPN, DOC and other staff. [665]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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 when a person had reasonable grounds to suspect abuse of a resident, which resulted in harm to the resident, shall immediately report the suspicion and information to the Director.

Rationale and Summary

The home submitted a critical incident system (CIS) report to the Ministry of Long-Term Care (MLTC) for resident to resident physical abuse regarding an incident. Resident #003 was pushed by resident #002, fell and sustained injuries. The critical incident was not reported to the Director until the following day.

The Associate Director of Care (ADOC) acknowledged that the incident was abuse

and was not reported to the Director immediately.

Failure of the home to report the incident to the Director did not place the residents at risk, but the home's management of critical incidents and reporting matters to the Director may not have been as effective.

Sources: Review of CIS report #2837-000038-23, residents #002 and #003's progress notes and interviews with ADOC and other staff. [665]

WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A resident sustained a fall and began experiencing pain a few hours later. The next day, staff documented the resident was having difficulty with locomotion and required staff assistance. On a specified date, the resident reported pain in their lower extremity and was provided with an analgesic for pain relief. The effectiveness of the analgesic post-administration was evaluated for the resident and they expressed increased pain. However, the home did not complete a pain assessment for the resident when their pain was not relieved by initial interventions. The resident was not provided analgesic for pain relief again until several days later.

The resident was later transferred to hospital and diagnosed with an injury. The resident indicated during an interview that they had ongoing pain until they started receiving scheduled pain medications over a week after the fall.

The DOC confirmed that when the resident's initial pain intervention was ineffective, staff did not conduct the "Pain Assessment", which is the home's assessment instrument for pain. The DOC also indicated that in this instance, the staff was also required to review the intervention with the home's physician. However there was no documentation that this had occurred for the resident.

Failure to assess the resident's pain using a clinically appropriate assessment instrument specifically designed for pain compromised the home's ability to identify the resident's pain severity and delayed the resident's treatment for pain.

Sources: Resident's clinical records; home's policy "Pain & Symptom Management", VII-G-30.30, last revised April 2019; interview with resident and DOC. [000707]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Educate PSW #115 on resident #005's plan of care related to a resident's transferring and positioning requirements.
2. Educate PSW #115 on safe transferring and positioning techniques per the home's policies.
3. Maintain a record of the education, including the content, date, signatures of staff who attended and the staff member who provided the education.
4. Conduct three random audits per week of PSW #115 during the provision of transferring assistance using a mechanical lift to residents for a period of three weeks from service of this order, or until nine audits have been completed, whichever occurs first.
5. Maintain a record of audits completed, including but not limited to, date of audit, person completing the audit, resident audited, outcome and actions taken as a result of any deficiencies identified.

Grounds

The home has failed to ensure that Personal Support Worker (PSW) #115 used safe transferring techniques when assisting resident #005.

Rationale and Summary

Resident #005 required a specific device and assistance from two staff for all transfers. On a specified date, PSW #115 manually lifted the resident from their mobility aid without a second staff member present. The resident was standing and holding onto an assistive device. While PSW #115 moved the resident's mobility aid, the resident lost their balance and fell to the floor. Prior to the transfer, another PSW had offered assistance with the transfer and PSW #115 declined. The resident was transferred to hospital on a later date and diagnosed with an injury.

PSW #115 acknowledged they did not follow the resident's care plan for transfers.

RPN and ADOC confirmed the resident required a specific device for transfers at the time of the fall and it was not appropriate for PSW #115 to manually transfer the resident by themselves.

Failure to ensure that PSW #115 used a safe transferring technique resulted in injury to resident #005.

Sources: Resident #005's clinical records; home's investigation notes; interviews with resident #005, PSW #115, RPN, and ADOC. [000707]

This order must be complied with by January 24, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO issued on January 25, 2023 in inspection 2022-1322-0002 to O. Reg. 246/22, s. 40

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.