Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 22, 2017	2017_449619_0003	011407-15, 011802-15, 021845-15, 022377-15, 022445-15, 023979-15, 024749-15, 025419-15, 028414-15, 034977-15, 005130-16, 008115-16, 013250-16, 017429-16, 017758-16, 017882-16, 017883-16, 018289-16, 018676-16, 019527-16, 019623-16, 022412-16, 022466-16, 023022-16, 026165-16, 026544-16, 026570-16, 026946-16, 027094-16, 029808-16, 031825-16, 033042-16, 033354-16, 001754-17	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Hawthorn Woods Care Community
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

SAMANTHA DIPIERO (619), JESSICA PALADINO (586)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, 2017, and March 1, 2017

The following critical incident inspections were done concurrently with this Resident Quality Inspection:
025419-15 - in relation to falls
033042-16 - in relation to falls
028414-15 - in relation to falls
013250-16 - in relation to falls
021845-15 - in relation to falls
031825-16 - in relation to falls
027094-16 - in relation to falls
001754-17 - in relation to falls
022412-16 - in relation to falls
023022-16 - in relation to falls
022377-15 - in relation to falls
034977-15 - in relation to falls
008115-16 - in relation to an unexpected death
022466-16 - in relation to skin and wound care
026544-16 - in relation to personal support services
026165-16 - in relation to responsive behaviours
018676-16 - in relation to responsive behaviours
017883-16 - in relation to responsive behaviours
026570-16 - in relation to responsive behaviours
033354-16 - in relation to responsive behaviours
017882-16 - in relation to responsive behaviours
017758-16 - in relation to responsive behaviours
032714-16 - in relation to responsive behaviours
019527-16 - in relation to the prevention of abuse
017429-16 - in relation to the prevention of abuse

029808-16 - in relation to the prevention of abuse
024749-15 - in relation to the prevention of abuse
019623-16 - in relation to the prevention of abuse
011802-15 - in relation to the prevention of abuse
018289-16 - in relation to the prevention of abuse
022445-15 - in relation to the prevention of abuse
005130-16 - in relation to the prevention of abuse
026946-16 - in relation to the prevention of abuse
011407-15 - in relation to the prevention of abuse

During the course of the inspection, the inspector(s) spoke with the Adminstrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager, Food Services Manager (FSM), Physiotherapist (PT), Occupational Therapist (OT), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Behavioural Support Ontario Registered Nurse (BSO RN), Dietary Aide, Activation Staff, residents, and families.

During the course of the inspection, LTCH Inspectors toured the home, conducted interviews, observed the provision of care and services, reviewed relevant records, policies and procedures and resident health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to ensure that every resident was protected from abuse.

A) On an identified date in March 2015, activation staff #107 heard arguing between resident #001 and dietary staff #106 in the dining room, where their voices were raised. Activation staff #107 noted the resident had a glass of liquid in their hand and was attempting to throw it at dietary staff #106 when the staff member grabbed the glass from the resident's hand and threw the liquid onto the resident. Activation staff #107, along with two staff members also in the dining room, confirmed that there was liquid on the resident. Internal investigation notes, along with interview with the FSM and Administrator on an identified date in February 2017, confirmed that dietary staff #106 threw liquid onto the resident. Resident #001 was not protected from emotional abuse by staff member #106.

B) On an identified date in May 2015, resident #002 reported to staff that PSW #108 gestured inappropriately to the resident and called them a name using extremely derogatory terms. Review of the home's internal investigation notes and interview with the home's Administrator confirmed that the details of the PSW #108's actions brought forward by the resident were verified and that their actions were unacceptable. Interview with the Administrator on an identified date in February 2017, confirmed that resident #002 was not protected from verbal abuse by PSW #108.

C) On an identified date in June 2016, resident #019 was observed as displaying physically abusive responsive behaviours towards resident #023. Interview with PSW #117 indicated that after being alerted by yelling from resident #023. PSW #117 indicated that when the staff attempted to distract and remove resident #019; the resident grabbed resident #023 causing injury resident #023. A review of resident #019's progress notes indicated that the resident was displaying physical and verbal responsive behaviours towards staff and other residents on five (5) dates preceding the incident with resident #023.
Interview with RN #120 indicated that the resident was not being monitored at the time of the incident and indicated that resident #019 should have already been on Direct Observational Screening (DOS) monitoring in relation to the increase in physically aggressive responsive behaviours. Interview with BSO RN #109 indicated that staff were required to initiate DOS monitoring when there was an increase in a resident's responsive behaviours so that staff could monitor, identify, and evaluate the resident's responsive behaviours and responses to interventions. A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident", policy # VII-G-10.00, last revised January 2015, stated, "All residents have the right to dignity, respect, and freedom from abuse and neglect. The organization has a zero tolerance policy for resident abuse and neglect. Abuse and neglect are not tolerated in any circumstances by anyone". Interview

with the Administrator and ADOC #102 confirmed that staff failed to initiate monitoring protocols that were pertinent to the resident's increased, ongoing responsive behaviours and that as a result, resident #023 was not protected from abuse from resident #019.

D) Resident #028 required assistance from two (2) staff for transfers with the use of a sit to stand lift. On an identified date in June 2016, resident #028 reported to PSW #119 that they had been the recipient of rude and negative remarks from PSW #118 during the provision of care, and that PSW #118 often times did not assist the resident to transfer. In an interview, resident #028 stated that on an unspecified date, PSW #118 was assisting them in the bathroom, told them that they "complain too much" when the resident verbally expressed pain during the provision of care. Resident #028 further stated that PSW #118 would routinely insist that they transfer themselves from bed to wheelchair and that other PSW's would come back and assist them to transfer safely. Resident #028 stated that they felt PSW #118's attitude made them feel anxious, insulted, and burdensome to the care giver. Resident #028 also stated that they had reported the allegation of emotional abuse to PSW #119 previously on more than one occasion and was unaware of any action taken on their behalf. A review of the homes policy titled, "Prevention of Abuse & Neglect of a Resident", policy # VI-G-10.00, last revised January 2015, stated, "All residents have the right to dignity, respect, and free from abuse and neglect. The Organization has a Zero Tolerance policy for resident abuse and neglect". The Ontario Regulations 79/10 define emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident", a review of the complaint made by resident #028 fits the definition of emotional abuse. Interview with ADOC #102 confirmed that PSW #118 failed to treat the resident with respect and dignity and caused them to feel that they were not treated with dignity and respect.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids, and positioning aids in the home in accordance with manufacturer's instructions.

Resident #009's primary mode of locomotion was by mobility device and they did not have a history of falls. On an identified date in October 2016, resident #009 fell out of their mobility device which resulted in an injury. The home's internal investigation notes indicated that the resident's mobility device was not secured correctly and concluded that this likely contributed to the fall.

The OT assessed the resident's mobility post-fall and corrected the issue. Interview with the OT on an identified date February 2017, confirmed that because the fixture on the mobility device was not installed correctly it could not secure properly. The OT indicated that it was highly unlikely that the resident would have been able to do this themselves, and that this likely happened due to the mobility device being washed or cleaned and not put back together correctly.
The OT provided the LTCH Inspector with policy #TRD0225, information sheet which the OT stated was applied to resident #009's mobility device. The recommendations provided for safe installation and use indicated that the appropriate re-installation of the mobility device fixture included ensuring the supporting fixtures were adhered and secured.

Interview with the ADOC confirmed that the mobility device was not maintained in accordance with the manufacturer's instructions which was a contributing factor to resident #009's fall with fracture.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee failed to ensure that the home was equipped with a resident – staff communication and response system that could easily be seen, accessed and used by residents, staff, and visitors at all times.

On an identified date in February 2017, Long-Term Care Homes (LTCH) Inspector observed resident #021 resting in bed and noted that the resident's call bell was clipped to their pillow. Resident #021 was unable to advise the LTCH Inspector where the call bell was, stating that they could neither see, nor feel the call bell, and could not access the call bell cord. A review of the resident's care plan initiated on an on identified date in March 2015, indicated that the resident required the call bell to be placed in a specific fashion for ease of use. Interview with RN #110 indicated that the resident required the call bell to be placed in a fashion that is easily accessible to them, because the resident would otherwise be unable to access the response system on their own, and indicated that this was not completed for the resident. Interview with ADOC #101 confirmed that the staff failed to ensure that the resident had easy access to the resident-staff response system.

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 with r. 17(1) where every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

Without in any way restricting the generality of the duty provided for in section 19, the licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A) On an identified date in August 2016, resident #021 was found in their room with a noted injury. A critical incident report was not submitted to the Director until two (2) days later on a second identified date in August 2016. As per the critical incident report, the home reported the potential abuse based on the potential for it being related to a resident to resident abuse, or a potential staff to resident abuse. As determined later in the internal investigation, resident #021 was not a victim of abuse. Interview with the Assistant Director of Care (ADOC) #101 confirmed that as per the home's Zero Tolerance policy, Registered staff are responsible for calling the Ministry's reporting line when members of the home's management team are not available. ADOC #101 confirmed that the home failed to immediately report the suspicion of abuse to the Director and did not follow their Zero Tolerance policy.

B) On an identified date in June 2016, resident #028 reported to PSW #119 that the day shift PSW #118 was rude when speaking to them on several occasions. In an interview, resident #028 stated that PSW #118 was unhelpful when they asked for assistance for locomotion in their mobility device, and was told by PSW #118 that the resident complained too much. In an interview PSW #119 stated that resident #028 informed them on "several occasions" that they felt PSW #118 was rude and unhelpful and that the actions of PSW #118 were upsetting to them, and did not report this to the charge nurse for further investigation.

A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident", policy #VII-G-10.00, last revised January 2015, stated, "All employees, volunteers, staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Direction/Administrator or designate in charge of the home." Interview with Administrator confirmed that PSW #119 failed to report the allegation of emotional abuse when first brought forward by the resident and that the staff failed to comply with the home's anti-abuse policy.

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 with s. 20(1) without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date in August 2016, resident #032's Substitute Decision Maker (SDM), notified RPN #115 of a change in the resident's skin condition. Interview with PSW #114 indicated that resident #032 required assistance from two staff to complete all lifts and transfer with the use of a device. An interview with PSW #116 indicated that they provided care to resident #032 on the night shift bridging the evening of an identified date in August 2016, to the following morning. PSW #116 indicated that they provided care alone to the resident and did not receive assistance from a second staff member to transfer the resident from their bed to their mobility device via the lift device. A review of the resident's written plan of care, updated in July 2016, indicated that the resident required two (2) staff to transfer via a lift. A review of the home's policy titled, "Resident Transfer & Lift Procedures", policy #VII-G-20.20, last revised April 2016, stated, "The PSW will lift/transfer the resident according to the plan of care". Interview with DOC confirmed that PSW #116 completed an unsafe transfer causing injury to resident #032 as they did not transfer the resident according to the instructions in the resident's written plan of care and that the resident obtained an injury as a result of the improper transfer.

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 with r. 36 where every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

The home's policy titled, "Skin & Wound Care Management Program", policy #VI-G-10.80, last revised April 2016, stated, "Registered staff will "complete resident skin assessments and ….initiate an electronic weekly skin assessments".
A) On an identified date in August 2016, resident #032's Substitute Decision Maker

(SDM) alerted RPN #114 to an injury. Interview with PSW #116, who was identified as the night shift care giver for resident #032, indicated that they observed an old injury. Interview with RN #111 indicated that registered staff were to complete an initial skin and wound assessment followed by a weekly skin assessment until the injury was resolved. The resident's injury was assessed with the use of a clinically appropriate assessment tool once per shift for seventy two (72) hours, for a total of nine (9) assessments. Interview with RN #111 indicated that the resident's injury did not resolve for a period lasting longer than two weeks and was not further assessed with a clinically appropriate assessment tool on a weekly basis until the injury resolved.

B) On an identified date in June 2016, resident #023 received an injury as a result of a physical altercation involving resident #019 who was asserted physically aggressive responsive behaviours on them. A review of the resident's physical assessment's indicated that resident #019 developed minor injuries to two specified areas on their person. A review of the skin and wound assessments indicated that the resident's skin was assessed once per shift by the registered staff for a total of seventy two (72) hours. Interview with RN #111 indicated that the resident's injury did not resolve for a period of more than two weeks and was not further assessed with a clinically appropriate assessment tool on a weekly basis until the wound resolved.

C) On an identified date in June 2016, resident #033 obtained an injury as a result of a fall. A review of the resident's skin and wound assessments indicated that the resident was assessed with the use of a clinically appropriate assessment tool once per shift for a period of seventy two (72) hours. Interview with RN #111 indicated that the resident's injury did not resolve in a seventy two (72) hour period and was not further assessed with a clinically appropriate assessment tool on a weekly basis until the wound resolved.

D) Resident #015 had a history of pain and had previously undergone a procedure prior to admission to the home in September 2015. On an identified date in May 2016, after complaining of increased pain, a diagnostic test determined that the resident's had an injury and infection related to the prior procedure and the resident was sent to hospital for further treatment. The resident returned to the home on an identified date in May 2016, and required ongoing an identified intervention related to altered skin integrity. A review of the resident's health record indicated that resident #015 was re-admitted to hospital on two separate occasions in June 2016. A review of the resident's skin and wound assessments indicated that resident #015 did not receive a weekly skin assessment for three identified weeks in the months of May 2016 and June 2016 for a total of three (3) missing weekly skin and wound assessments.

Interview with RPN #123 indicated that when a resident returns from hospital, an initial skin and wound assessment is completed and following that, a weekly assessment is to be initiated. Interview with RN #111 indicated that registered staff were to complete skin assessments on a resident who had a change in their skin condition once per shift for seventy-two (72) hours, for a total of nine (9) skin and wound assessments as well as initiating a weekly skin and wound assessment. Interview with the DOC confirmed that registered staff failed to ensure that residents with altered skin integrity and wounds were not re-assessed on a weekly basis.

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 with r. 50. (2) where every licensee of a long-term care home shall ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including but not limited to assessments, reassessments and interventions and that the resident's responses to interventions were documented.

On an identified date in June 2016, resident #019 was observed exhibiting responsive behaviours towards resident #023 which caused physical harm to resident #023. Resident #019 had a history of responsive behaviours; care plan last revised April 2016, identified that the resident's behaviours included physical and verbal aggression, and unpredictable behaviour. A review of the resident's progress notes indicated that the resident had a change in status in the days prior to the incident on an identified date in June 2016. A review of the resident's Direct Observation Screening (DOS) monitoring record indicated that the resident's behaviour was observed by staff for a period of seventy two (72) hours on identified date in June 2016. Interview with RN #120 indicated that when a resident displays responsive behaviours the registered staff can initiate DOS monitoring to assess the resident's behaviours and responses to interventions. Interview with BSO RN #120 indicated that no new assessments or interventions were initiated for resident #019 until after resident #019 caused physical harm to resident #023 on an identified date in June 2016. A review of the home's policy titled, "Responsive Behaviours – Management", policy # VII-F-10.20, last revised October 2016, stated, "the registered staff will conduct and document an assessment of the resident experiencing behaviours to include completing behavioural assessments based on resident need including but not limited to Direct Observational Screening (DOS) monitoring". Interview with ADOC #103 confirmed that staff failed to take action in response to the needs of resident #019 who was exhibiting physically and verbally aggressive responsive behaviours.

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 with r. 53(4) where the licensee shall ensure that, for each resident demonstrating responsive behaviours (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that every resident of a long-term care home had his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

On an identified date in February 2016, LTCH Inspectors identified a record containing the personal health information of eighteen (18) residents. This sheet, titled "Frequent Incontinence Needing Extra Change" was observed taped to the white board located in the nursing station. This sheet was observed to be visible to staff, residents, and visitors to this unit. This sheet posted the names of eighteen (18) residents and identified diagnoses.
Interview with PSW #114 indicated that staff referred to this incontinence list as a reminder to check residents, and indicated that this list had been posted for approximately one week. Interview with ADOC #101 confirmed that incontinence sheets were produced for staff reference only and should not have been posted in an open area in the home where the personal health information of these eighteen resident's would be visible to non-staff members. ADOC #101 confirmed that the staff failed to protect the resident's personal health information.

WN #9: 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. (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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee failed to ensure that the resident was re-assessed and the plan of care reviewed and reviewed at least every six months and at any other time when the resident's care needs change, or care set out in the plan of care was no longer necessary.

On an identified date in August 2016, resident #021 was found in bed by a PSW staff with two (2) injuries related to an identified change in status. A review of the resident's written plan of care indicated that for a period encompassing an identified date in August 2016, to an identified date in November 2016, the resident's written plan of care was not updated to include the resident's change in status. Interview with BSO RN #109 indicated that when there is a change in the resident's condition or an increase in the resident's responsive behaviours that new interventions are to be updated in the plan of care to communicate these changes and planned interventions to staff who provide care to the resident. Interview with ADOC #101 confirmed that the plan of care was not revised when the resident's care needs changed.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure that the plan, policy, procedure, strategy, or system instituted or otherwise put in place was complied with.

On an identified date in August 2016, resident #021 was found to be displaying responsive behaviours. A review of the home's internal investigation indicated that the resident was noted to have a minor injury.
A review of the home's policy titled, "Responsive Behaviours – Management", policy # VII-F-10.20, last revised October 2016, stated that, "The registered staff will conduct an assessment of the resident exhibiting responsive behaviours to include: completing behavioural assessments based on resident needs, including but not limited to Dementia Observation System (DOS) monitoring". A review of the resident's progress notes and the resident's health record did not indicate that DOS monitoring was initiated after the change in the resident's responsive behaviours was noted on an identified date in August 2016. Interview with BSO RN #109 indicated that registered staff were responsible for initiating DOS monitoring to assess and evaluate the resident's change in condition as part of the home's responsive behaviour program. Under the Long Term Care Homes Act, 2007, the nursing home was required to have a program related to the management of responsive behaviours, and were required to comply with their program policies. Interview with ADOC #101 confirmed that the registered staff failed to comply with the home's responsive behaviours policy when they failed to initiate DOS monitoring for resident #021.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

The licensee failed to ensure training was provided to staff regarding the cleaning and sanitizing of equipment relevant to the staff member's responsibilities.

On an identified date in October 2016, resident #009 fell out of their mobility device which resulted in an injury. The home's internal investigation notes indicated that a supporting fixture (which according to the OT was supposed to be secured inside the mobility device's cover) was outside of the mobility device which prevented the supporting fixture from adhering to the mobility device's frame. The investigation concluded that this contributed to the fall.
Task documentation confirmed that PSW #121 cleaned the resident's mobility device on an identified date in October 2017. Interview with PSW #121 on an identified date in February 2017, confirmed this. They confirmed that they have never received formal training on how to clean resident mobility devices. Interview with the ADOC #101 in February 2017, also confirmed that staff do not receive training on cleaning mobility devices.

Issued on this 30th day of March, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMANTHA DIPIERO (619), JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2017_449619_0003
Log No. / Registre no:	011407-15, 011802-15, 021845-15, 022377-15, 022445-15, 023979-15, 024749-15, 025419-15, 028414-15, 034977-15, 005130-16, 008115-16, 013250-16, 017429-16, 017758-16, 017882-16, 017883-16, 018289-16, 018676-16, 019527-16, 019623-16, 022412-16, 022466-16, 023022-16, 026165-16, 026544-16, 026570-16, 026946-16, 027094-16, 029808-16, 031825-16, 033042-16, 033354-16, 001754-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 22, 2017
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Hawthorn Woods Care Community
9257 Goreway Drive, BRAMPTON, ON, L6P-0N5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Linda Joseph-Massiah

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To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee is hereby ordered to:
a. Ensure that all residents, including but not limited to resident #001, #002, #019, and #028 are protected from abuse by anyone.
b. Provide education and training for all staff in relation to procedures and interventions to assist and support residents who have been allegedly abused whether suspected or witnessed to promote zero tolerance of abuse and neglect of residents.
c. Ensure staff comply with the home's policy in relation to the prevention of abuse and neglect

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual harm/risk
Scope: Isolated
Compliance History: This non-compliance was issued as a VPC on May 24, 2016

2. The licensee failed to ensure that every resident was protected from abuse.

A) On an identified date in March 2015, activation staff #107 heard arguing between resident #001 and dietary staff #106 in the dining room, where their voices were raised. Activation staff #107 noted the resident had a glass of liquid in their hand and was attempting to throw it at dietary staff #106 when the staff member grabbed the glass from the resident's hand and threw the liquid onto the resident. Activation staff #107, along with two staff members also in the dining room, confirmed that there was liquid on the resident. Internal

investigation notes, along with interview with the FSM and Administrator on an identified date in February 2017, confirmed that dietary staff #106 threw liquid onto the resident. Resident #001 was not protected from emotional abuse by staff member #106.

B) On an identified date in May 2015, resident #002 reported to staff that PSW #108 gestured inappropriately to the resident and called them a name using extremely derogatory terms. Review of the home's internal investigation notes and interview with the home's Administrator confirmed that the details of the PSW #108's actions brought forward by the resident were verified and that their actions were unacceptable. Interview with the Administrator on an identified date in February 2017, confirmed that resident #002 was not protected from verbal abuse by PSW #108.

C) On an identified date in June 2016, resident #019 was observed as displaying physically abusive responsive behaviours towards resident #023. Interview with PSW #117 indicated that after being alerted by yelling from resident #023. PSW #117 indicated that when the staff attempted to distract and remove resident #019; the resident grabbed resident #023 causing injury resident #023. A review of resident #019's progress notes indicated that the resident was displaying physical and verbal responsive behaviours towards staff and other residents on five (5) dates preceding the incident with resident #023. Interview with RN #120 indicated that the resident was not being monitored at the time of the incident and indicated that resident #019 should have already been on Direct Observational Screening (DOS) monitoring in relation to the increase in physically aggressive responsive behaviours. Interview with BSO RN #109 indicated that staff were required to initiate DOS monitoring when there was an increase in a resident's responsive behaviours so that staff could monitor, identify, and evaluate the resident's responsive behaviours and responses to interventions. A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident", policy # VII-G-10.00, last revised January 2015, stated, "All residents have the right to dignity, respect, and freedom from abuse and neglect. The organization has a zero tolerance policy for resident abuse and neglect. Abuse and neglect are not tolerated in any circumstances by anyone". Interview with the Administrator and ADOC #102 confirmed that staff failed to initiate monitoring protocols that were pertinent to the resident's increased, ongoing responsive behaviours and that as a result, resident #023 was not protected from abuse from resident #019.

D) Resident #028 required assistance from two (2) staff for transfers with the use of a sit to stand lift. On an identified date in June 2016, resident #028 reported to PSW #119 that they had been the recipient of rude and negative remarks from PSW #118 during the provision of care, and that PSW #118 often times did not assist the resident to transfer. In an interview, resident #028 stated that on an unspecified date, PSW #118 was assisting them in the bathroom, told them that they "complain too much" when the resident verbally expressed pain during the provision of care. Resident #028 further stated that PSW #118 would routinely insist that they transfer themselves from bed to wheelchair and that other PSW's would come back and assist them to transfer safely. Resident #028 stated that they felt PSW #118's attitude made them feel anxious, insulted, and burdensome to the care giver. Resident #028 also stated that they had reported the allegation of emotional abuse to PSW #119 previously on more than one occasion and was unaware of any action taken on their behalf. A review of the homes policy titled, "Prevention of Abuse & Neglect of a Resident", policy # VI-G-10.00, last revised January 2015, stated, "All residents have the right to dignity, respect, and free from abuse and neglect. The Organization has a Zero Tolerance policy for resident abuse and neglect". The Ontario Regulations 79/10 define emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident", a review of the complaint made by resident #028 fits the definition of emotional abuse. Interview with ADOC #102 confirmed that PSW #118 failed to treat the resident with respect and dignity and caused them to feel that they were not treated with dignity and respect.
(586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee shall ensure that staff use all equipment, supplies, devices, assistive aids, and positioning aids in the home in accordance with the manufacturer's instructions. This shall include the proper maintenance of resident #009's wheelchair cushion.

Specifically, the licensee shall:
1. Ensure all direct care staff are trained on how resident personal equipment, including wheelchair cushions, are intended to be used in accordance with manufacturer's instructions,

2. Ensure all staff are trained in relation to the proper cleaning and sanitizing of equipment used by residents, relevant to the staff member's responsibility,

3. Develop a protocol to be used by staff for inspecting and assessing each resident's personal equipment, including wheelchairs, after the item has been cleaned to ensure it is in proper condition for the resident's safety, and

4. Develop an auditing process to ensure that all resident personal equipment is being cleaned and sanitized appropriately and that the items are being used in accordance with manufacturer's instructions to provide safety for the resident.

Grounds / Motifs :

1. Judgment Matrix:
- Non-Compliance Severity: Actual harm or risk for actual harm
- Non-Compliance Scope: Isolated
- Compliance History: Despite Ministry of Health (MOH) action, non-compliance (NC) continues with original area of NC.

2.The licensee failed to ensure training was provided to staff regarding the cleaning and sanitizing of equipment relevant to the staff member's responsibilities.

On an identified date in October 2016, resident #009 fell out of their mobility device which resulted in an injury. The home's internal investigation notes indicated that a supporting fixture (which according to the OT was supposed to be secured inside the mobility device's cover) was outside of the mobility device which prevented the supporting fixture from adhering to the mobility device's frame. The investigation concluded that this contributed to the fall.
Task documentation confirmed that PSW #121 cleaned the resident's mobility device on an identified date in October 2017. Interview with PSW #121 on an identified date in February 2017, confirmed this. They confirmed that they have never received formal training on how to clean resident mobility devices.
Interview with the ADOC #101 in February 2017, also confirmed that staff do not receive training on cleaning mobility devices.
(586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Samantha Dipiero

Service Area Office /
Bureau régional de services : Hamilton Service Area Office