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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2017	2017_544527_0011	022444-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF2063414 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

KATHLEEN MILLAR (527), HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 20, 21, 25, 26, 27, 28 and 29, 2017.

During this inspection, the inspections listed below were conducted concurrently:

Critical Incident Inspections:
019077-17 related to alleged staff to resident physical abuse
020890-17 related to alleged staff to resident physical and emotional abuse

Inquiry/Complaint Inspection:
005338-17 related to infection prevention and control

Follow-Up Order Inspections:
Compliance Order #001, Log #006814-17 related to s. 19
Compliance Order #002, Log #006816-17 related to s. 23

During the course of the inspection, the inspector(s) spoke with The Administrator/Executive Director, the Director of Care (DOC), the Assistant Directors of Care (ADOC), the Nurse Manager, the registered nurses and registered practical nurses, the Personal Support Workers (PSW), the Environmental Services Director, the Laundry Aides, the Registered Dietician (RD), the Physiotherapist (PT), the office Manager, the Resident Relations Coordinator, the Director of Resident Programs, the Minimum Data Set-Resident Assessment Instrument (MDS-RAI) Coordinator, the President of the Family Council, the President of the Residents' Council, the residents and family members.

During the course of the inspection the inspectors toured the home, conducted interviews, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **7 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_449619_0003	527
O.Reg 79/10 s. 23.	CO #002	2017_449619_0003	527

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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A) Resident #022 was admitted to the home and had a Bowel and Bladder Continence Assessment completed, which identified the resident had no daytime incontinence. The Minimum Data Set (MDS) assessed the resident to be occasionally incontinent. The written plan of care directed staff that the resident had occasional incontinence, was to be continent during waking hours through the review date and used incontinence products. The plan of care directed staff to remind the resident to go to the washroom with staff and to toilet resident as per their need. The plan of care was not individualized to support the resident to maximize their abilities to achieve their highest level of continence and did not include measures to be taken to promote the resident's normal bladder function.
The policy called "Continence Program - Guidelines for Care", number VII-D-10.00, and revised January 2015, directed staff to ensure that all residents had an individualized program of continence care developed and documented on the plan of care that directed staff as to the measures to be taken to promote the resident's normal bowel and bladder function and continence care products required to meet the resident's needs for comfort, dignity and choice.
The policy called "Continence Program - Promoting Continence", number VII-D-10.10, and revised January 2015, directed staff to provide support to the resident to maximize their abilities to achieve the highest level of continence. All Nursing Staff will adhere to the resident's individualized care plan, which will include the following: Scheduled times for checking, changing and toileting residents; resident specific toileting regimen for the continent or potentially continent resident and specific product usage for the incontinent

resident.
In July 2017, the resident's MDS assessment identified the resident to be frequently incontinent of bladder, which was a decline from the previous assessments. The written plan of care included no revisions or changes to the plan of care related to the decline in the residents level of continence. The plan of care was not individualized to support the resident to maximize their abilities to achieve their highest level of continence nor revised to reflect the change in level of continence.
During an interview with the Resident Assessment Instrument (RAI) Coordinator, they informed the Long Term Care Home (LTCH) Inspector#640 that they were not aware the plan of care was not updated to reflect the changes to the resident's incontinence and was not individualized to reflect the changes. The Assistant Director of Care (ADOC) #106 was interviewed as the Continence Lead for the home. They told the LTCH Inspector they expected the written plan of care to be updated to reflect changes in a resident's level of continence and this had not been done. ADOC #106 confirmed the plan of care was not individualized based on the assessment of the resident and did not support the resident to maximize their abilities to achieve their highest level of continence.

B) Resident #024 was admitted and had a Bowel and Bladder Continence Assessment completed, which identified the resident with both day and night incontinence.
The Minimum Data Set (MDS) assessed the resident to be frequently incontinent of bowel and bladder. Several months later another Bowel and Bladder Continence Assessment was completed and revealed the resident had both day and night incontinence. The written plan of care dated directed staff that the resident had incontinence, was to remain dry and comfortable by the next quarter and used incontinence products. The plan of care directed staff to routinely check the resident's brief. The plan of care was not individualized to support the resident to maximize their abilities to achieve their highest level of continence.
In August 2017, the resident's MDS assessment identified occasionally incontinent of bowel and incontinent of bladder, which was a decline in continence. The written plan of care identified the resident was incontinent of bladder and directed staff that the resident had bladder incontinence, was to remain dry and comfortable by the next quarter and used incontinence products. The plan of care directed staff to routinely check the resident's brief. The plan of care was not individualized to support the resident to maximize their abilities to achieve their highest level of continence.
During an interview with the Resident Assessment Instrument (RAI) Coordinator, they informed the Long Term Care Home (LTCH) Inspector #640 that they were not aware the plan of care was not updated to reflect the changes to the resident's bladder

incontinence and was not individualized to reflect the changes.
The Assistant Director of Care (ADOC) #106 was interviewed as the Continence Lead for the home. They told the LTCH Inspector they expected the written plan of care to be updated to reflect changes in a resident's level of continence and this had not been done. ADOC #106 confirmed the plan of care was not individualized based on the assessment of the resident and did not support the resident to maximize their abilities to achieve their highest level of continence.

C) Resident #023 was admitted and had a Bowel and Bladder Continence Assessment completed, which identified the resident with no daytime incontinence. The Minimum Data Set (MDS) assessed the resident to be usually continent of bowel and bladder. Another Bowel and Bladder Continence Assessment was completed, which revealed the resident to have a sudden onset of incontinence. The written plan of care directed staff that the resident had continence, was to remain continent by the next quarter and used incontinence products. The plan of care was not individualized to reflect the assessment of sudden onset of incontinence and to support the resident to maximize their abilities to achieve their highest level of continence.
In June 2017, the resident's MDS assessment identified usually continent of bowel and frequently incontinent of bladder. The written plan of care identified the resident was continent of bladder and was to maintain continence by the next quarter. The plan of care was not individualized to reflect the assessment of sudden onset of incontinence and to support the resident to maximize their abilities to achieve their highest level of continence.
During an interview with the Resident Assessment Instrument (RAI) Coordinator, they informed the Long Term Care Home (LTCH) Inspector #640 that they were not aware the plan of care was not updated to reflect the changes to the resident's bladder incontinence and was not individualized to reflect the changes. The Assistant Director of Care (ADOC) #106 was interviewed as the Continence Lead for the home. They told the LTCH Inspector they expected the written plan of care to be updated to reflect changes in a resident's level of continence and this had not been done to reflect the assessment completed May 2017, and the subsequent MDS assessment June 2017. ADOC #106 confirmed the plan of care was not individualized based on the assessment of the resident and did not support the resident to maximize their abilities to achieve their highest level of continence.

The licensee failed to ensure that resident #022, #023 and #024 who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

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. 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 :

1. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including a continence care and bowel management, programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

A) Resident #022 was admitted to the home and was assessed using the MDS assessment to be occasionally incontinent. A Bowel and Bladder Continence assessment was completed, which identified no daytime urinary incontinence. In July 2017, a Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment was completed which revealed the resident's continence to have declined to frequently incontinent. A Bowel and Bladder Continence Assessment was not completed by the

home related to this decline in urinary continence.
The home's policy called "Resident Assessments", number VII-C-10.70, and revised January 2015, directed staff to complete a Bowel and Bladder Continence Assessment when a resident had a change in status.
During an interview with the DOC, they confirmed there was an expectation that a Bowel and Bladder Continence Assessment to be completed as resident #022’s urinary continence had declined since admission. (640)

B) Resident #012 was observed in September 2017, with a bed rail in place. The resident was further observed over several days, with the same bed rail in place.
The resident's plan of care was reviewed, which indicated the resident needed one bed rail to support routine activities of daily living, related to bed mobility. The resident was assessed in August 2017, which was incomplete. The nursing section, the summary documentation and the Bed Rail decision sections of the assessment were blank. The resident also had a Personal Assistive Services Device (PASD) assessment completed by the registered staff, which was also incomplete.
The home's policy called "Bed Safety Program", number VII-E-10.18, and revised May 2017, was reviewed. The policy directed the interdisciplinary team to conduct an individualized resident assessment to use or remove a bed rail, and to complete the assessment on the electronic Bed Rail assessment tool in Point Click Care (PCC). If it was determined the bed rail was necessary, the individual resident assessment would include but not limited to: medical diagnosis; medication; sleep habits; cognition; and mobility.
RPN #115 was interviewed and confirmed the resident was assessed using the Restraint/PASD tool in PCC and the resident needed one bed rail for bed mobility and positioning. The RPN was not aware that the registered staff were required to complete the Bed Rail assessment tool in PCC. The RPN also confirmed that both assessment tools related to the resident's bed rails were incomplete.
The Director of Care (DOC) was interviewed and indicated that the new Bed Safety program was implemented in May 2017, and the interdisciplinary team were educated on the new process in June 2017. The DOC confirmed the interdisciplinary team members, such as registered staff, were expected to complete the Bed Rail assessment tool in PCC related to the resident's bed rails as per the home's policy and were not to complete the Restraint/PASD assessment tool for bed rails.
The home failed to ensure that staff complied with their new Bed Safety program policies and procedures as it related to the bed rail assessments for resident #012.

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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, meets quarterly to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary to improve the system.

The Long Term Care Homes (LTCH) Inspector#640 reviewed the home's quarterly evaluations of the medication management system dated February, May and September 2017.
The Administrator was not in attendance at the quarterly evaluations of the medication management system for February, May and September 2017. In September 2017, the pharmacy service provider was also not in attendance at the quarterly evaluation of the medication management system.
The minutes were reviewed with the Administrator and the Director of Care and they confirmed the Administrator and the pharmacy service provider was not in attendance at the quarterly evaluations of the medication management system and in September 2017.

2. The licensee failed to ensure that the quarterly evaluation of the medication management system included (b) review of any medication incident reports and adverse drug reactions referred to in subsection 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action was necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and (c) identification of any changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Quarterly evaluations of the medication management system dated February, May and September 2017, were reviewed by the Long Term Care Home (LTCH) Inspector#640 with the Administrator and the Director of Care (DOC). They confirmed the quarterly evaluations of the medication management system did not include a review of any medication incident reports and adverse drug reactions and did not include the identification of any changes to improve the system in accordance with evidence-based practices and where there were none, in accordance with prevailing practices.
The licensee did not ensure that the quarterly evaluation of the medication management system included a review of their medication incident reports and adverse drug reactions

and the identification of any changes to improve the medication management system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, and to ensure that the quarterly evaluation of the medication management system must include at least, (a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; (b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and (c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary to improve the system.

The Long Term Care Homes (LTCH) Inspector#640 reviewed the annual evaluation of the medication management system for 2016. The Administrator was not in attendance for this evaluation. The minutes were reviewed with the Administrator who confirmed they were not in attendance.

2. The licensee failed to ensure the annual evaluation of the medication management system must, include a review of the quarterly evaluations in the previous year as referred to in section 115.

The minutes of the annual evaluation of the medication management system for 2016 were reviewed by the Long Term Care Homes (LTCH) Inspector #640, the Administrator and the Director of Care (DOC) confirmed the quarterly evaluations of the medication management system had not been reviewed as part of the annual evaluation of the medication management system for the 2016 year.

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 interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) (iv) drugs were stored in an area or medication cart, that complied with manufacturer's instructions for the storage of drugs.

During review of the government stock medication storage cupboard, a random audit was conducted by the LTCH Inspector #640 with the Director of Care (DOC) related to expired medications kept in the government medication supply cupboard. There were medications that had expired in January, March, April, July and September, 2017. The LTCH Inspector identified a plastic bag containing a number of medications which expired in 2012.
The home's policy called "The Medication Storage", number 3-4, and revised February 2017, directed staff to monitor expiry dates on a regular basis (monthly), especially medications that were used whenever necessary (PRN) for resident, narcotic medications, treatment areas and extra medication areas. Government Stock medications were to have expiry dates monitored on a regular basis (monthly was suggested).
RN #121 reviewed the contents of the government medication storage cupboard with the LTCH Inspector and confirmed there were a number of medications that were expired and remained in the active storage cabinet.
The DOC was interviewed and confirmed there were medications that had expired that were to be discarded from the supply.
The licensee did not comply with the manufacturers instructions for the storage of drugs.

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, (a) drugs were stored in an area or a medication cart, (iv) that complied with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #6: 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 :

1. The licensee failed to ensure that the resident was 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 was no longer necessary.

Resident #007 was admitted to the home and had multiple medical conditions.
During an interview with the resident, they told the Long Term Care Homes (LTCH) Inspector #640 that physiotherapy (PT) no longer provided a specific treatment yet they found there were some relief with the therapy. Resident #007 informed the LTCH Inspector they often use another type of therapy to assist with pain management.
Review of the written plan of care identified that the specific treatment was being provided by physiotherapy on an as needed basis. The written plan of care did not identify the intervention of the use of an additional therapy to assist with pain relief.
PSW #122 was interviewed and informed the LTCH Inspector that the resident does use their own therapy.
During an interview with RN #121, they confirmed the resident did use their own therapy but was not sure how often. The RN included that PT provided a specific intervention to the resident. The LTCH Inspector informed the RN that during an interview with the Physiotherapist, the LTCH Inspector was told the specific intervention had been discontinued. RN #121 confirmed the specific intervention provided by PT remained on the written plan of care and the use of the resident's own therapy for pain relief, was not included in the written plan of care. The RN indicated that when the resident's therapy was used, a progress note would be written.
The clinical record was reviewed, which included the progress notes for two month period in 2017, and there was no documentation found related to the use of the resident's therapy.
The Physiotherapist (PT) was interviewed and informed the LTCH Inspector #640 that they no longer provided treatment for resident #007 and the specific intervention was discontinued.
The ADOC #106 was interviewed and confirmed that the written plan of care should reflect the current treatment plan in place. The specific intervention provided by the PT should have been discontinued, and the use of the resident's therapy for pain relief should have been included in the plan of care.
The licensee did not ensure that resident #007 was reassessed and the plan of care reviewed and revised when the resident's care needs changed or when the resident's care set out in the plan was no longer necessary.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

The Long Term Care Home (LTCH) Inspector reviewed the home's government medication stock supply. The home had a large quantity of multiple medications.
The home's policy called "The Medication Storage", number 3-4, and revised February 2017, directed staff to monitor utilization of government stock on the inventory log and order accordingly. The policy also directed staff to stock inventory in accordance with the Ministry of Health Long Term Care Home Act, 2007, which directed licensee's to keep less than three months' supply on hand. One month supply was recommended.
During an interview with the DOC, they were not clear on the utilization of government stock medications.
The home's drug utilization documentation was reviewed; however this document did not identify the utilization of the government stock medications.
The DOC confirmed there was more government medication stock than needed for a three month supply for the home.

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

Issued on this 26th day of October, 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) :	KATHLEEN MILLAR (527), HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2017_544527_0011
Log No. / No de registre :	022444-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 25, 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 :	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

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:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The Licensee shall ensure that:

1) Resident #022, #023 and #024 receive a continence assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.
2) Resident #022, #023 and #024 have an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder developed and implemented.
3) Staff are trained on the home's Continence for bowel and bladder policy and procedures.
4) The licensee implement an audit process to ensure that residents identified as declining in bowel and bladder receive an assessment, and have an individualized plan of care developed and implemented to promote and manage bowel and bladder.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (3), in keeping with s.299(1) of the Regulation, in respect of the lack of individualized care to resident #022, #023 and #024, the scope which was widespread, and the Licensee's history of noncompliance.

2. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A) Resident #022 was admitted to the home and had a Bowel and Bladder Continence Assessment completed, which identified the resident had no daytime incontinence. The Minimum Data Set (MDS) assessed the resident to be occasionally incontinent. The written plan of care directed staff that the resident had occasional incontinence, was to be continent during waking hours through the review date and used incontinence products. The plan of care directed staff to remind the resident to go to the washroom with staff and to toilet resident as per their need. The plan of care was not individualized to support the resident to maximize their abilities to achieve their highest level of continence and did not include measures to be taken to promote the resident's normal bladder function.

The policy called "Continence Program - Guidelines for Care", number VII-D-10.00, and revised January 2015, directed staff to ensure that all residents had an individualized program of continence care developed and documented on the plan of care that directed staff as to the measures to be taken to promote the resident's normal bowel and bladder function and continence care products required to meet the resident's needs for comfort, dignity and choice.
The policy called "Continence Program - Promoting Continence", number VII-D-10.10, and revised January 2015, directed staff to provide support to the resident to maximize their abilities to achieve the highest level of continence. All Nursing Staff will adhere to the resident's individualized care plan, which will include the following: Scheduled times for checking, changing and toileting residents; resident specific toileting regimen for the continent or potentially continent resident and specific product usage for the incontinent resident.
In July 2017, the resident's MDS assessment identified the resident to be frequently incontinent of bladder, which was a decline from the previous assessments. The written plan of care included no revisions or changes to the plan of care related to the decline in the residents level of continence. The plan of care was not individualized to support the resident to maximize their abilities to achieve their highest level of continence nor revised to reflect the change in level of continence.
During an interview with the Resident Assessment Instrument (RAI) Coordinator, they informed the Long Term Care Home (LTCH) Inspector #640 that they were not aware the plan of care was not updated to reflect the changes to the resident's incontinence and was not individualized to reflect the changes. The Assistant Director of Care (ADOC) #106 was interviewed as the Continence Lead for the home. They told the LTCH Inspector they expected the written plan of care to be updated to reflect changes in a resident's level of continence and this had not been done. ADOC #106 confirmed the plan of care was not individualized based on the assessment of the resident and did not support the resident to maximize their abilities to achieve their highest level of continence.

B) Resident #024 was admitted and had a Bowel and Bladder Continence Assessment completed, which identified the resident with both day and night incontinence.
The Minimum Data Set (MDS) assessed the resident to be frequently incontinent of bowel and bladder. Several months later another Bowel and Bladder Continence Assessment was completed and revealed the resident had both day and night incontinence. The written plan of care dated directed staff that the resident had incontinence, was to remain dry and comfortable by the next

quarter and used incontinence products. The plan of care directed staff to routinely check the resident's brief. The plan of care was not individualized to support the resident to maximize their abilities to achieve their highest level of continence.
In August 2017, the resident's MDS assessment identified occasionally incontinent of bowel and incontinent of bladder, which was a decline in continence. The written plan of care identified the resident was incontinent of bladder and directed staff that the resident had bladder incontinence, was to remain dry and comfortable by the next quarter and used incontinence products. The plan of care directed staff to routinely check the resident's brief. The plan of care was not individualized to support the resident to maximize their abilities to achieve their highest level of continence.
During an interview with the Resident Assessment Instrument (RAI) Coordinator, they informed the Long Term Care Home (LTCH) Inspector#640 that they were not aware the plan of care was not updated to reflect the changes to the resident's bladder incontinence and was not individualized to reflect the changes.
The Assistant Director of Care (ADOC) #106 was interviewed as the Continence Lead for the home. They told the LTCH Inspector they expected the written plan of care to be updated to reflect changes in a resident's level of continence and this had not been done. ADOC #106 confirmed the plan of care was not individualized based on the assessment of the resident and did not support the resident to maximize their abilities to achieve their highest level of continence.

C) Resident #023 was admitted and had a Bowel and Bladder Continence Assessment completed, which identified the resident with no daytime incontinence. The Minimum Data Set (MDS) assessed the resident to be usually continent of bowel and bladder. Another Bowel and Bladder Continence Assessment was completed, which revealed the resident to have a sudden onset of incontinence. The written plan of care directed staff that the resident had continence, was to remain continent by the next quarter and used incontinence products. The plan of care was not individualized to reflect the assessment of sudden onset of incontinence and to support the resident to maximize their abilities to achieve their highest level of continence.
In June 2017, the resident's MDS assessment identified usually continent of bowel and frequently incontinent of bladder. The written plan of care identified the resident was continent of bladder and was to maintain continence by the next quarter. The plan of care was not individualized to reflect the assessment of sudden onset of incontinence and to support the resident to maximize their

abilities to achieve their highest level of continence.
During an interview with the Resident Assessment Instrument (RAI) Coordinator, they informed the Long Term Care Home (LTCH) Inspector #640 that they were not aware the plan of care was not updated to reflect the changes to the resident's bladder incontinence and was not individualized to reflect the changes. The Assistant Director of Care (ADOC) #106 was interviewed as the Continence Lead for the home. They told the LTCH Inspector they expected the written plan of care to be updated to reflect changes in a resident's level of continence and this had not been done to reflect the assessment completed May 2017, and the subsequent MDS assessment June 2017. ADOC #106 confirmed the plan of care was not individualized based on the assessment of the resident and did not support the resident to maximize their abilities to achieve their highest level of continence.

The licensee failed to ensure that resident #022, #023 and #024 who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

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
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Name of Inspector / Nom de l'inspecteur : Kathleen Millar

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