

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

**Rapport d'inspection prévue  
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**

Central West Service Area Office  
1st Floor, 609 Kumpf Drive  
WATERLOO ON N2V 1K8  
Telephone: (888) 432-7901  
Facsimile: (519) 885-2015

Bureau régional de services de Centre  
Ouest  
1e étage, 609 rue Kumpf  
WATERLOO ON N2V 1K8  
Téléphone: (888) 432-7901  
Télécopieur: (519) 885-2015

**Public Copy/Copie du public**

---

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>No de registre</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|--|---|-----------------------------------|--|
| Jul 9, 2019                                    | 2019_739694_0009                              | 005290-19                         | Complaint  |

---

**Licensee/Titulaire de permis**

2063414 Ontario Limited as General Partner of 2063414 Investment LP  
302 Town Centre Blvd. Suite 300 MARKHAM 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**

AMANDA COULTER (694)

---

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

---

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): May 28, 29, 30, 31, and June 4, 2019.**

**The following intake was completed during this inspection: Log #005290, IL 64870 related to Prevention of Abuse and Neglect.**

**A Critical Incident System (CIS) inspection #2019\_739694\_0010 was completed concurrently.**

**During the course of this inspection the inspector toured the home and observed residents care, services and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents and procedures as related to the inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.**

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

**Falls Prevention**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Sufficient Staffing**

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

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

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

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

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

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

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specific date in February 2019, an identified resident's Substitute Decision Maker (SDM) attended the home to visit the resident. They found the resident in a location, not in view of staff, visibly uncomfortable and upset, not wearing appropriate clothing.

The SDM reported their concerns to the home the next day and the home completed a critical incident system (CIS) report.

The home's investigation notes included interviews with the nursing staff that were assigned to the identified resident's care on the specific date. They stated that they provided care to the resident and acknowledged they were aware of the identified resident's care needs as directed by their plan of care.

The home's investigation verified that nursing staff failed to ensure the identified resident's plan of care was not followed related to dressing and ensuring they were placed in view of staff for close monitoring. When the resident was found by family they were visibly uncomfortable and upset.

The licensee failed to ensure that a resident was provided care in relation to dressing and monitoring as specified in their plan of care. [s. 6. (7)]

***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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

**Issued on this 10th day of July, 2019**

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

**Original report signed by the inspector.**