Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 21, 2019	2019_545147_0008	013180-19	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

LALEH NEWELL (147)

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): August 7, 8, 9, 12 and 13, 2019.

The following intake was completed in this Complaint inspection:

Log # 013180-19 - related to Falls Prevention.

This inspection was conducted concurrently with Critical Incident System (CIS) Inspection #2019-545147-0009.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Registered Nurses, Registered Practical Nurses, Personal Support Workers, family members and residents.

During this inspection, inspector(s) toured resident care areas; reviewed relevant clinical records, policies and procedures, home's investigation notes; observed the provision of resident care, resident-staff interactions, and observed the cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 resident #002's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint received to the Ministry of Long Term Care (MLTC) by resident#002's Substitute Decision Maker (SDM) stated that resident #002 had numerous falls since their admission to the home. However, they were not provided the opportunity to participate fully in the development and implementation of the resident's plan of care related to falls prevention strategies.

Review of resident #002's clinical records and assessments showed that resident #002 had multiple falls during a three month period in 2018. Resident #002 was admitted to the home and assessed for risk for falls and falls prevention strategies were put in place and the plan of care for the resident updated to reflect these strategies.

The resident had additional falls in 2019 and on a specific date in January 2019, the resident fell and sustained injuries. Review of the plan of care for resident #002 and interview with staff # 104 stated that the plan of care was updated with additional falls preventions strategies after the fall.

Interview with the DOC and review of the progress notes related to the falls, showed that there was no documented evidence to support that the resident's SDM was given the opportunity to participate fully in the development and implementation of the resident's plan of care related to Falls preventions prior to the fall in January 2019.

The SDM shared that the home had not shared the changes to the resident's plan of care

related to falls with them. They were not aware that falls interventions strategies were put in place for the resident until after the January 2019 fall.

The licensee failed to ensure that resident #002's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to falls prevention strategies. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan related to falls prevention.

A complaint received to the Ministry of Long Term Care (MLTC) by resident#002's SDM who indicated that resident #002 had numerous falls and that the home had not followed the care set out in the plan for the resident as specified in the plan related to falls prevention.

Review of the clinical records for resident #002 showed that the resident fell numerous times between a three month period in 2019. On a specific dated in January 2019, the resident fell and sustained injuries. Review of the plan of care for resident #002 and interview with staff #104 stated that the plan of care was updated with additional falls preventions strategies after the fall.

The plan of care was reviewed and under the risk of falls focus it included specific fall interventions to be in place for the resident. However, it was also evident through review of the investigation notes that the staff did not ensure that these fall interventions were in place at the time of resident #002's fall in January 2019.

The licensee failed to ensue that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan related to falls prevention. [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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care and that the care set out in the plan of care for is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 22nd day of August, 2019

[redacted]

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

Original report signed by the inspector.