

**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
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Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 15, 2019	2019_826606_0024	017594-19	Critical Incident System

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

JANET GROUX (606)

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): October 22 and 23, 2019.

The following Critical Incident System (CIS) was inspected:

Log # 017594-19 regarding a resident transfer that resulted in a serious injury.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physiotherapist (PT), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records such as progress notes, assessments, physician orders, written care plans, reviewed relevant home's investigation records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition

Personal Support Services

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

1 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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 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 :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

A Critical Incident System (CIS) reported that resident #001 sustained a serious injury

during care.

Resident #001's progress notes stated that Personal Support Worker (PSW) #104 reported to Registered Practical Nurse (RPN) #102 that the resident became unsteady and was unable to support themselves to stand during care. The PSW stated that they held on to the resident and PSW #103 came to assist them with the transfer. Resident #001 complained of discomfort afterward and was assessed by the Physiotherapist (PT) who felt the resident had sustained an injury. The resident verbalized pain during motion and they were transferred to hospital for further assessments and treatment.

An identified home's policy directed the PSWs to use transfer and repositioning aides according to the plan of care.

Resident #001's Minimum Data Set (MDS) 2.0 Quarterly Assessment for an identified date and their plan of care identified that resident #001 was at risk for falls due to their physical conditions and required a specific number of staff and an identified level of assistance for ADLs.

PSW #104 stated that resident #001's abilities to stand and support themselves were not always reliable. They stated that on the identified date, as they provided care, resident #001 was not able to support themselves and lost their balance. They called for PSW #103 who was able to assist them with the resident to a safe position. PSW #104 acknowledged that resident #001 required an specific number of staff for an identified ADL.

PSW #103 confirmed that resident #001 required an identified number of staff for a specified ADL. RPN #102 and the Resident Assessment Instrument (RAI) Coordinator confirmed this.

The PT stated that resident #001's ability to support themselves was unreliable due to their medical conditions and required a specific level of assistance for an identified ADL. The PT confirmed that because the resident's ability to support themselves was unreliable, the resident always required a specific number of staff to assist them for an identified ADL which included transfers from sitting to standing.

The home's investigation concluded that PSW #104 did not follow the resident's plan of care and transferred resident #001 in an unsafe manner resulting in a serious injury.

The licensee has failed to ensure that staff used safe transferring techniques to transfer resident #001.

Additional Required Actions:

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

Issued on this 25th day of November, 2019

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) : JANET GROUX (606)

Inspection No. /

No de l'inspection : 2019_826606_0024

Log No. /

No de registre : 017594-19

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Nov 15, 2019

Licensee /

Titulaire de permis : 2063414 Ontario Limited as General Partner of 2063414
Investment LP
302 Town Centre Blvd., Suite 300, MARKHAM, 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 : Adam Kertesz

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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(s) of the Inspector

Ordre(s) de l'inspecteur

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

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. 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.

Order / Ordre :

The Licensee must comply with O.Reg 79/10, s. 36.

Specifically, the home must:

- a) Ensure that staff use safe transferring and positioning devices or techniques when assisting any resident.
- b) Ensure that the plan of care for all residents includes the level of assistance required for transfers and assistance in relation to bathing.
- c) Ensure that staff have convenient access to the plan of care which provides direction related to transfers and bathing.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents.

A Critical Incident System (CIS) reported that resident #001 sustained a serious injury during care.

Resident #001's progress notes stated that Personal Support Worker (PSW) #104 reported to Registered Practical Nurse (RPN) #102 that the resident became unsteady and was unable to support themselves to stand during care. The PSW stated that they held on to the resident and PSW #103 came to assist them with the transfer. Resident #001 complained of discomfort afterward and was assessed by the Physiotherapist (PT) who felt the resident had sustained an injury. The resident verbalized pain during motion and they were transferred to hospital for further assessments and treatment.

An identified home's policy directed the PSWs to use transfer and repositioning

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aides according to the plan of care.

Resident #001's Minimum Data Set (MDS) 2.0 Quarterly Assessment for an identified date and their plan of care identified that resident #001 was at risk for falls due to their physical conditions and required a specific number of staff and an identified level of assistance for ADLs.

PSW #104 stated that resident #001's abilities to stand and support themselves were not always reliable. They stated that on the identified date, as they provided care, resident #001 was not able to support themselves and lost their balance. They called for PSW #103 who was able to assist them with the resident to a safe position. PSW #104 acknowledged that resident #001 required a specific number of staff for an identified ADL.

PSW #103 confirmed that resident #001 required an identified number of staff for a specified ADL. RPN #102 and the Resident Assessment Instrument (RAI) Coordinator confirmed this.

The PT stated that resident #001's ability to support themselves was unreliable due to their medical conditions and required a specific level of assistance for an identified ADL. The PT confirmed that because the resident's ability to support themselves was unreliable, the resident always required a specific number of staff to assist them for an identified ADL which included transfers from sitting to standing.

The home's investigation concluded that PSW #104 did not follow the resident's plan of care and transferred resident #001 in an unsafe manner resulting in a serious injury.

The licensee has failed to ensure that staff used safe transferring techniques to transfer resident #001.

The severity was a level three as there was actual harm to the resident which resulted in a significant change in their condition.

The scope was isolated as one out of three residents inspected was affected.

The home's compliance history was a level three with a previous non compliance (NC) to the same subsection.

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.
O. 2007, chap. 8

(606)

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

Feb 17, 2020

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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O. 2007, chap. 8

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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health Services Appeal and Review Board and the Director

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

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.

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Ordre(s) de l'inspecteur

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O. 2007, chap. 8

**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, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
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O. 2007, chap. 8

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)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 15th day of November, 2019

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Janet Groux

Service Area Office /

Bureau régional de services : Central West Service Area Office