Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Sep 11, 2020	2020_738753_0020	012993-20, 013171-20	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

KATHERINE ADAMSKI (753), VALERIE GOLDRUP (539)

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 20-21, 24-28, 2020

The following intakes were completed during this complaint inspection:
Log # 012993-20 and Log # 013171-20, complaints related to resident care

NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 6 (7) was identified in a concurrent inspection #2020_738753_0019 (Log #011211-20) and issued in this report.

During the course of the inspection, the inspector(s) spoke with Interim Executive Director (ED), Temporary Director of Care (DOC), RAI-Coordinator, Registered Practical Nurses (RPNs), Residents, Personal Support Workers (PSWs), and Maintenance Staff.

During the course of the inspection, the inspectors observed resident and staff interactions, reviewed clinical health records, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services

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. (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 has failed to ensure that care set out in the plan of care was provided to resident #004 as specified in their plan related to fall prevention interventions.

Resident #004 required interventions to mitigate the risk of falling.

Resident #004 was not provided interventions as per their plan of care related to falls prevention and this resulted in an incident where they caught themselves mid-fall. The resident was emotionally distressed, remained fearful of falling, and suffered mild pain as a result of this incident.

During this inspection, inspector #753 observed that interventions were not implemented as per the resident's plan of care.

Sources: Inspector observations, interview's with the resident and their POA, DOC #102 and other staff, electronic records including progress notes, care plan, risk management. [s. 6. (7)]

2. The licensee has failed to ensure that fall prevention interventions were provided to resident #002 as specified in their plan of care related to fall prevention interventions.

Resident #002 was a high falls risk and required interventions for mitigating injury and assisting in falls prevention.

During this inspection, multiple observations showed that the resident did not have interventions implemented as per their plan of care.

Staff acknowledged that the resident did not have the interventions in place.

By not having the required interventions in place for mitigating injury or assisting in falls prevention, the risk of the resident sustaining a fall or an injury as a result of a fall was increased.

Sources: Inspector observations, interview's with staff, electronic records including care plan, kardex. [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 care set out in the plan of care for resident #002 and #004 is provided as specified in their plans related to fall prevention interventions, to be implemented voluntarily.

Issued on this 15th day of September, 2020

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

Original report signed by the inspector.