

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

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2021	2021_781729_0002	023394-20, 025281- 20, 025707-20	Critical Incident System

Licensee/Titulaire de permis2063414 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**

KIM BYBERG (729), 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): January 5-8, 13-15, 2021.

The following intakes were completed within the Critical Incident inspection:

-Log #023394-20, and Log #025281-20, related to a resident transfer to the hospital with a significant change in their health status,

-Log #025707-20, related to an allegation of neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist Assistant (PTA), Physiotherapist, Dietary aide, Residents and Families.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, schedules, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

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 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 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 :

The licensee has failed to ensure that resident #001 and #002 had fall prevention interventions in place as directed by their care plan.

Resident # 001 and #002 were observed to not have specific fall and injury prevention interventions in place as directed by their plan of care. They were at high risk for falls and their care plan directed the staff to make sure that these interventions were in place at all times.

The home not ensuring that resident #001 and #002 were wearing their hip protectors put the residents at risk for injury in the event that they had a fall.

Sources: observation, careplan, and PSW and RPN interview.

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 residents as specified in the plan, to be implemented voluntarily.***

Issued on this 1st day of February, 2021

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

Original report signed by the inspector.