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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
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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 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
Sep 27, 2021	2021_792659_0019	007332-21, 008013-21, 012198-21	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

JANETM EVANS (659), 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 16, 17, 18, 19, 24, 25, 26, and 27, 2021.

The following intakes were included in this inspection:
Log #012198-21 related to a resident fall with injury and care concerns.
Log #007332-21 related to a resident fall with injury
Log #008013-21 related to a resident fall with injury

This inspection was completed concurrently with Critical Incident System (CIS) Inspection # 2021_792659_0018

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Assistant Directors of Care (ADOCs), Dietitian, Dietary Manager (DM), Environmental Service Manager (ESM) Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), screeners, housekeepers, residents and family members.

Observations were completed of resident dining and snack services, Infection Prevention and Control (IPAC) procedures, the home's air temperature, staff to resident interactions and general care and cleanliness of the home. The following records were reviewed including but not limited to: progress notes, care plans, assessments, electronic Medication administration records, reports, home's investigations and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dining Observation
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Snack Observation

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was free from neglect by the licensee or staff in the home.

For the purpose of the Act and this Regulation, “neglect” means the failure to provide a resident with the treatment, care services, or assistance required for health safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s.5.

A resident was admitted to the home and passed away within a month of their admission. An assessment completed prior to their admission said the resident was at risk for falls and had an unsteady gait.

The resident's mobility was assessed and it was documented that they would benefit from a mobility aid.

The resident's plan of care indicated the resident was at risk for falls when attempting to transfer or mobilize independently. Staff were directed to implement two person assist for transfers and to monitor the resident whenever they were ambulating.

The resident never received a mobility aid, and there was no documentation to support the resident was assessed for mobility aids. Over a two week period, the resident attempted to self transfer independently 27 times and on seven occasions the resident ambulated independently without assistance or supervision.

On an identified date, resident #001 had an unwitnessed fall in their room and sustained an injury. A progress note entry by the staff requested that the day nurse inquire about a high low bed for the resident. There was no documented follow up for this request nor

were there any new fall prevention interventions added to the resident's plan of care. Staff said they had not followed up on the request as no one had communicated this to them.

The next day, the resident fell and sustained an injury and was sent to hospital.

The ED said staff did not follow the home's processes to alert the management team when the resident required mobility aids and fall prevention equipment.

The day after returning from hospital, the resident's diet texture was downgraded due to a change in condition. Staff did not notify the dietary department, or update the resident's plan of care as per the home's policy. As a result an incident occurred during the resident's lunch meal and the resident passed away four days later.

Failure to update the resident's plan of care when their health status changed and current interventions were not effective related to falls prevention and feeding/swallowing, as well as the failure to follow the home's documented processes and policies put the resident at risk for injury and resulted in harm to the resident.

Sources: progress notes, care plan, fall risk, transfer assessment, InterRAi Home Care MDS form dated May 20, 2021, Documentation Survey report, Falls Prevention & Management policy VII-G, Management of Dysphaia & Choking Risk, VII-I-10.80 dated May 2021, Management of a choking Resident, XVIII-D-10.60i (a) dated April 2021, training records, interview with ED, ADOC #115, Dietitian #118, Dietary Manager #121 and staff. [s. 19. (1)]

Additional Required Actions:

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

WN #2: 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 related to falls prevention was provided to a resident as specified in their plan.

A resident was assessed at risk for falls and had a history of falls with injury. Their plan of care for falls prevention directed staff to monitor the resident for safety and ensure a chair alarm was activated when the resident was in their wheelchair or tilt chair.

The resident was observed seated in a tilt chair in the lounge without their chair alarm. The wireless chair alarm was observed in the resident's room on a table.

Failure to ensure the plan of care for falls prevention for the resident was provided, placed the resident at risk for falls and potential injury.

Sources: observations, care plan, progress notes, fall risk, interview with RPN #113. [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 staff follow the plan of care related to falls interventions for a specified resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was notified no later than three business days after a resident fell and sustained an injury and a subsequent significant change in the resident's health status.

O. Reg. 79/10, s. 107, defined “significant change” as a major change in the resident’s health condition that,
(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident’s health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident’s plan of care.

A resident sustained a fall and required hospital care and treatment. Upon return to the home, the resident experienced a significant change in their health condition, and passed away four days later.

A Critical Incident Summary (CIS) report was not submitted to the Director related to this incident.

Not ensuring the Director was notified about the resident's fall and significant change in health condition, may have prevented the Director from responding, if required.

Sources: progress notes, plan of care, physician orders, Brampton Civic Hospital Emergency room records CSC, interviews with DOC, ED and staff. [s. 107. (3.1)]

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 a Critical Incident System report is submitted to the Director when a significant change has been determined, to be implemented voluntarily.

Issued on this 8th day of October, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANETM EVANS (659), VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2021_792659_0019
Log No. / No de registre :	007332-21, 008013-21, 012198-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 27, 2021
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 :	Rachel Muise

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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 # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must comply with s. 19.1 of the LTCHA, 2007.

Specifically, the licensee must ensure residents of the home are not neglected.

The licensee shall:
1. Re-educate all registered staff on the fall prevention and management program to reduce the incidence of falls and the risk of injury to residents. The education should include but not be limited to:

-reviewing the home's process for reassessing individual resident fall prevention strategies to determine their effectiveness
- the process for implementation of new strategies when current strategies are not effective
- the follow-up process in relation to referrals for assessments

The education should be documented and include: the date, a staff sign off list, the content and the name of the person providing the education. The documentation should be maintained onsite at the home.

2. Develop, educate and implement a written procedure for accessing equipment for resident use as part of the falls prevention program. The procedure should include a written communication process with the name of the person requesting and the date it was implemented. The education should be documented and include: the date, staff sign off, who provided the training, and content of the education. The documentation should be maintained onsite at the home.

3. Re-educate all direct care staff and registered staff on the management and feeding of residents with dysphagia or risk of choking or aspiration. The education must include how to assess a resident for readiness to feed, feeding techniques, the process for implementing diet changes and updating the resident's plan of care. The education must be documented and include: the date, staff sign off, the name of the person who provided the training, and the content of the training. The documentation should be maintained onsite at the home.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a resident was free from neglect by

the licensee or staff in the home.

For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care services, or assistance required for health safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s.5.

A resident was admitted to the home and passed away within a month of their admission. An assessment completed prior to their admission said the resident was at risk for falls and had an unsteady gait.

The resident's mobility was assessed and it was documented that they would benefit from a mobility aid.

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The resident never received a mobility aid, and there was no documentation to support the resident was assessed for mobility aids. Over a two week period, the resident attempted to self transfer independently 27 times and on seven occasions the resident ambulated independently without assistance or supervision.

On an identified date, resident #001 had an unwitnessed fall in their room and sustained an injury. A progress note entry by the staff requested that the day nurse inquire about a high low bed for the resident. There was no documented follow up for this request nor were there any new fall prevention interventions added to the resident's plan of care. Staff said they had not followed up on the request as no one had communicated this to them.

The next day, the resident fell and sustained an injury and was sent to hospital.

The ED said staff did not follow the home's processes to alert the management team when the resident required mobility aids and fall prevention equipment.

The day after returning from hospital, the resident's diet texture was downgraded due to a change in condition. Staff did not notify the dietary department, or update the resident's plan of care as per the home's policy. As a result an incident occurred during the resident's lunch meal and the resident passed away four days later.

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An order was made by taking the following factors into account:

Severity: Staff did not follow the home's documented procedures for updating resident #001's fall prevention interventions following a fall, nor did they follow the home's documented procedures for managing residents with dysphagia or choking risk. There was actual harm to resident #001 as they experienced a subsequent fall and choking with aspiration.

Scope: The scope of this non-compliance was isolated to one resident.

Compliance History: Four Written notifications (WN), seven Voluntary Plans of Correction (VPC) and two Compliance orders (CO) were issued to the home to unrelated sections of the legislation in the last 36 months.

(659)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 30, 2021

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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 revision 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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 27th day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

Service Area Office /
Bureau régional de services : Central West Service Area Office