Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West Service Area Office
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Original Public Report

Report Issue Date: October 18, 2022	
Inspection Number: 2022-1372-0004	
Inspection Type: Complaint	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Hawthorn Woods Care Community, Brampton	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature** Romela Villaspir Romela Villaspir 2022.10.18 13:15:43 -04'00'
Additional Inspector: Daniela Lupu (758)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 21-23, 26-30, 2022.

The following intake(s) were inspected:
-Intake: #00005642 related to skin and wound care, falls prevention and management, and nutrition and hydration.
-Intake: #00007632 related to responsive behaviours, and resident abuse.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: O. Reg. 79/10, s. 50. (2) (b) (ii)

The licensee has failed to ensure that a resident received immediate treatment to promote wound healing, as required.

Rationale and Summary
A resident was noted with a skin impairment by Personal Support Workers (PSWs) on four different days in March 2022.

The resident did not receive immediate treatment to promote healing, which resulted in worsening of the skin impairment.

Sources: Resident's clinical health records; Interviews with a PSW, Registered Practical Nurses (RPNs), the Wound Care Nurse (WCN), and Associate Director of Care (ADOC). [653]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: O. Reg. 79/10, s. 50. (2) (b) (iii)

The licensee has failed to ensure that a resident was assessed by a Registered Dietitian (RD) who was a member of the staff of the home in relation to a pressure ulcer.

Rationale and Summary
A resident was noted with a skin impairment by PSWs in March 2022.

The RD received a referral five months after it was first identified, at which point the skin impairment had already worsened.

There was moderate risk to the resident as the RD was unable to assess them, and implement dietary interventions to promote healing of the skin impairment when it was first identified.

Sources: Resident's clinical health records; Interviews with a PSW, RPNs, RD, the WCN, and ADOC. [653]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: O. Reg. 246/22, s. 55. (2) (d)

The licensee has failed to ensure that a resident who was dependent on staff for repositioning, was repositioned every two hours or more frequently as required.

Rationale and Summary
A resident was dependent on staff for repositioning.

The resident was noted with a skin impairment by PSWs in March 2022.

In July 2022, there was no progress in healing of the skin impairment.

A Registered Nurse (RN) indicated that prior to July 2022, the staff were not turning and repositioning the resident every two hours.

By not turning and repositioning the resident every two hours, the pressure on their skin impairment may not have been consistently offloaded, therefore, impeding healing.

Sources: Resident's clinical health records; Interviews with a PSW, RPNs, RN, the WCN, and ADOC. [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6. (5)

The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A resident was noted with a skin impairment by PSWs on four different days in March 2022.

The ADOC indicated that when a resident sustains a new skin impairment, the SDM would be notified, and this would be documented in the progress notes and risk management module.

The resident's SDM was not informed of the skin impairment noted by the PSWs.

Sources: Resident's clinical health records; Interviews with a PSW, RPNs, the WCN, and ADOC. [653]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#05 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: O. Reg. 246/22, s. 102. (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

A. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 10.4 (h), indicates that the hand hygiene program is to include policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals.

The home's Hand Hygiene Policy, #IX-G-10.10, last revised in December 2021, indicated that staff should offer residents hand hygiene prior to eating.

During a lunch meal service on a Resident Home Area (RHA), three PSWs did not encourage or assist 22 out of 23 residents with hand hygiene prior to eating.

A resident said they were not encouraged or assisted with hand hygiene before their meal. A PSW, RPN, and the home's former IPAC Lead/ ADOC said residents should be encouraged to perform hand hygiene before and after their meals.

Sources: Observation of a meal service; The home's hand hygiene policy, and the IPAC Standard (April 2022); Interviews with the home's former IPAC Lead/ ADOC, a PSW, resident, and other staff. [758]

B. The IPAC Standard for LTCHs, dated April 2022, section 9.1 indicates that Routine Practices and Additional Precautions should be followed in the IPAC program and should include proper

use of Personal Protective Equipment (PPE), such as appropriate selection, application, removal, and disposal.

i) The home's PPE policy #IX-G-10.20, last revised in March 2021, indicated that all team members should use professional judgment and guidelines in making a decision about the type of PPE to be used depending on the potential for direct contact with body fluid.

Routine Practices and Additional Precautions in All Health Care Settings, Provincial Infectious Diseases Advisory Committee (PIDAC), third edition, last revised in November 2012, indicated that if the face was exposed to a splash, spray, cough or sneeze, a facial protection should be worn. Gloves should be removed and discarded immediately after the activity for which they were used, after touching a contaminated site and before touching a clean site or the environment.

A screener did not wear eye protection when they collected nasal swabs from a visitor.

A PSW exited from a RHA with gloves on while carrying a garbage bag. The PSW touched the keypad of the service elevator door, then disposed the garbage bag and exited the room without removing their gloves.

The home's former IPAC Lead/ ADOC said staff should wear eye protection, mask, gown, and gloves when they collect nasal swabs from an individual. They also said staff should remove gloves before exiting a resident's room and should not touch clean items with the soiled gloves.

Sources: Observations of Rapid Antigen Testing (RAT) practices, PPE use with routine practices; IPAC Standard (April 2022), and the home's PPE policy; Interviews with the former IPAC Lead/ ADOC, screener, and other staff. [758]

ii) The home's Additional Precautions policy, IX-G-10.70, last revised in December 2021, indicated that when contact precautions were in place, staff should wear gloves and gown if skin or clothing came into direct contact with the resident or his/ her environment.

At the time of this inspection, a resident was on contact precautions. Region of Peel Contact Precautions - Donning PPE signage was posted on this resident's room door. The signage directed staff to wear a gown and gloves before entering the resident's room.

A PSW did not wear a gown when they entered the resident's room, and provided direct care to the resident.

The home's former IPAC Lead/ ADOC said a gown should have been worn in addition to gloves when providing direct care to a resident on contact precautions.

iii) A resident was placed on droplet and contact precautions. Region of Peel Droplet and Contact Precaution – Removal of PPE signage posted on this resident's room door directed staff to remove eye protection and discard mask or respirator before exiting the resident's room.

A RPN and a staff member exited the resident's room without removing their eye protection and N95 respirators, and went to the nursing station. The RPN obtained an N95 respirator at the nursing station and changed their N95 respirator and eye protection.

The Director of Care (DOC) said N95 respirators and eye protection should be removed and changed with new ones before exiting this resident's room.

Staff not using PPE according to the Routine and Additional Precautions increased the risk of spreading COVID-19 and other infectious microorganisms amongst residents, staff, and visitors.

Sources: Observations of PPE use with Contact and Droplet-Contact precautions; IPAC Standard (April 2022), Region of Peel Contact precautions Donning PPE signage, Region of Peel Droplet and Contact Precautions Removal of PPE signage, and the home's Additional Precautions policy; Interviews with a PSW, RPN, former IPAC Lead/ ADOC, DOC, and other staff. [758]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC#06 Written Notification pursuant to FLTCA, 2021, s.154(1)1
Non-compliance with: O. Reg. 79/10, s. 53. (4) (c)

The licensee has failed to ensure that the monitoring of a resident's responsive behaviours was documented.

Rationale and Summary

A resident had multiple responsive behaviours including inappropriate responsive behaviours towards two co-residents. A monitoring tool was initiated after three incidents had occurred with co-residents. Each time it was initiated, there were missing entries on the monitoring tool.

The home's Behavioural Support Ontario (BSO) Lead acknowledged the missing monitoring tool documentation and said the resident's behaviours could not be accurately assessed and analyzed due to missing documentation. The current DOC said the tool should be completed in its entirety for the duration of monitoring.

Gaps in the resident's behaviours documentation increased the risk that the resident's behaviours could not be accurately assessed, and appropriate interventions could not be identified and implemented.

Sources: Resident's progress notes, care plan, monitoring tool; Interviews with the BSO Lead, DOC, and other staff. [758]

COMPLIANCE ORDER CO#001 ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC#07 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a)

Compliance Order [FLTCA, 2021, s. 155(1)]
The Licensee has failed to comply with O. Reg. 79/10, s. 54. (b)

The licensee shall:

1. Develop and implement an audit to ensure:
    (a) Assessments and re-assessments of a resident's responsive behaviours, including but not limited to, nursing assessments to rule out physical and medical causes and cognitive and mood assessments, are completed according to the home's responsive behaviours management policy.
    (b) Interventions are identified and implemented based on those assessments.

2. The audit must include the date, person responsible for the audit, interventions implemented, actions taken when interventions are not effective. A record of this audit should be kept in the home.

3. The audit must be completed for four weeks, or until such time as compliance is achieved.

Grounds

Non-compliance with: O. Reg. 79/10, s. 54. (b)

The licensee has failed to identify and implement interventions to minimize the risk of harmful interactions between a resident and two co-residents.

Rationale and Summary

A resident had multiple responsive behaviours including inappropriate responsive behaviours towards two co-residents.

i) The resident wandered into a co-resident's room and touched an item on the co-resident while they were sleeping. A monitoring tool was initiated to track the resident's responsive behaviours, and an intervention was put in place to prevent the resident from wandering into the co-resident's room.

ii) Approximately six days after, the resident wandered into the co-resident's room again, and demonstrated inappropriate behaviour towards the co-resident. Following the incident, interventions were put in place, and a monitoring tool was initiated, but it was not completed as required, with several entries missing on several days.

iii) The resident wandered into another co-resident's room and demonstrated inappropriate behaviour towards the co-resident, who was observed to be in distress during the interaction.

No additional interventions were identified or implemented after the last incident, to monitor the resident's behaviours and minimize the risk of recurrence of their inappropriate behaviours.

The BSO Lead and former DOC stated that when current strategies were not effective, new interventions should have been implemented to address the resident's responsive behaviours and maintain safety of other residents.

Not identifying and implementing interventions to minimize the risk of potentially harmful interactions between and amongst residents posed a high risk to the two co-residents.

Sources: Critical Incident System (CIS) reports, residents' clinical records, the home's considerations for implementing 1:1 staffing policy, the home's responsive behaviours

management policy, LTC clinical pathway v7; Interviews with a PSW, RPNs, the home's BSO Lead, former and current DOC, and other staff. [758]

This order must be complied with by: November 28, 2022

COMPLIANCE ORDER CO#002 SKIN AND WOUND CARE

NC#08 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a)

Compliance Order [FLTCA, 2021, s. 155(1)]
The Licensee has failed to comply with O. Reg. 79/10, s. 50. (2) (b) (i)

The licensee shall:

1. Ensure PSWs and Registered Staff on a RHA are re-educated on the home's skin and wound policy, specific to the completion of assessments, when a resident exhibits a new altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.
2. Maintain records in the home of the re-education provided.

Grounds

Non-compliance with: O. Reg. 79/10, s. 50. (2) (b) (i)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when they exhibited altered skin integrity.

Rationale and Summary
A resident was noted with a skin impairment by PSWs on four different days in March 2022.

A clinically appropriate skin assessment was not completed until three weeks after the resident first showed signs of a skin impairment.

As a result of the delay in the skin assessment by a registered staff, the resident's skin impairment was not consistently monitored and treated by registered staff from the time it was first identified by the PSWs. The skin impairment progressed to an open wound.

Sources: Resident's clinical health records; Interviews with a PSW, RPNs, the WCN, and ADOC. [653]

This order must be complied with by: November 28, 2022

COMPLIANCE ORDER CO#003 SKIN AND WOUND CARE

NC#09 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a)

Compliance Order [FLTCA, 2021, s. 155(1)]
The Licensee has failed to comply with O. Reg. 246/22, s. 55. (2) (b) (iv)

The licensee shall:

1. Develop and implement an audit to ensure that all residents on a RHA with pressure ulcers, are reassessed weekly by a member of the registered nursing staff, based on the home's skin and wound policy. The audits should be conducted weekly for four weeks.
2. Ensure that when a weekly skin and wound assessment is not completed as identified through the weekly audit, the registered staff who missed the assessment is followed-up with.
3. Maintain records in the home of the audits conducted, and the follow-up actions taken.

Grounds

Non-compliance with: O. Reg. 246/22, s. 55. (2) (b) (iv)

The licensee has failed to ensure that a resident was reassessed at least weekly by a member of the registered nursing staff, when they had a pressure ulcer.

Rationale and Summary

An initial skin and wound assessment was completed for a resident's skin impairment, which identified a pressure ulcer.

The resident's pressure ulcer was not reassessed weekly by the registered staff for a period of almost four months.

The resident received the same dressing for their pressure ulcer for a period of three months.

By not reassessing the resident's pressure ulcer weekly for a period of almost four months, the wound was not consistently monitored, and dressing was not altered based on reassessment, which may have contributed to worsening of the wound.

Sources: Resident's clinical health records; Interviews with a PSW, RPNs, the WCN, and ADOC. [653]

This order must be complied with by: November 28, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.