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: January 3, 2023	
Inspection Number: 2022-1372-0005	
Inspection Type: Complaint Follow up	
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 Digitally signed by Romela Villaspir Date: 2023.01.03 16:49:54 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s): December 13-16, 20-21, 2022.

The following intake(s) were inspected:
-Intakes: # 00010992, #00012738, #00013791, #00014684, related to falls prevention and management, and skin and wound care.
-Intake: #00010879 follow-up to Compliance Order (CO) #001 of inspection #2022-1372-0004 with a Compliance Due Date (CDD) of November 28, 2022, related to altercations and other interactions between residents.
-Intake: #00011686 follow-up to CO #002 of inspection #2022-1372-0004 with a CDD of November 28, 2022, related to skin and wound care.
-Intake: #00010870 follow -up to CO #003 of inspection #2022-1372-0004 with a CDD of November 28, 2022, related to skin and wound care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **to be** in compliance:

Order #001 from inspection #2022-1372-0004 related to O. Reg. 79/10, s. 54. (b), inspected by Romela Villaspir (653).
Order #002 from inspection #2022-1372-0004 related to O. Reg. 79/10, s. 50. (2) (b) (i), inspected by Romela Villaspir (653).

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Order #003 from inspection #2022-1372-0004 related to O. Reg. 246/22, s. 55. (2) (b) (iv), inspected by Romela Villaspir (653).

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

Infection Prevention and Control
Falls Prevention and Management
Skin and Wound Prevention and Management
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that a resident who was incontinent, had an individualized plan as part of their plan of care, to promote and manage bowel and bladder continence.

Rationale and Summary

A resident was at risk for falls, and one of the falls prevention interventions in their care plan required the staff to toilet the resident according to their toileting plan.

The resident did not have a specific toileting plan or schedule.

On one occasion, the resident had an unwitnessed fall in their washroom, and a Registered Practical Nurse (RPN) found the resident on the floor beside the toilet.

By not having an individualized toileting plan, a consistent routine may not have been established, which increased the risk of the resident going to the washroom on their own, without staff assistance.

Sources: Resident's care plan; Interviews with the PSWs, RPN, RN, and the Associate Directors of Care (ADOCs). [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's written plan of care was provided to the resident as specified in the plan, as it related to a falls prevention intervention.

Rationale and Summary

A resident was at risk for falls, and one of the falls prevention interventions in their care plan required for a device to be in place at all times.

The resident had an unwitnessed fall in their bedroom. A PSW found the resident on the floor, near the bathroom door. The device was not in place at the time of the incident.

By not ensuring that the device was in place, staff were not alerted when the resident stood up from the bed.

The resident sustained an injury as a result of the fall.

Sources: Resident's care plan; Interviews with the PSW, RPN, and the ADOC. [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed, and the plan of care was reviewed and revised when their care needs changed.

Rationale and Summary

A resident sustained a wound as a result of a fall, and a specific dressing was initiated as per the home's skin and wound protocol.

Two weeks later, a RPN noted signs of infection on the resident's wound, and the physician ordered a topical treatment to be applied to the wound.

The initial dressing was not immediately removed from the resident's electronic Treatment Administration Record (eTAR).

By not reviewing and revising the resident's plan of care when their wound treatment changed, there

was potential risk that the initial dressing would be applied.

Sources: Resident's physician's orders, progress notes, electronic Medication Administration Record (eMAR), eTAR; Interviews with two RPNs, the Wound Care Nurse (WCN), and the ADOC. [653]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any action taken with respect to a resident under a program, including an intervention, and the resident's response to the intervention, were documented.

Rationale and Summary

A resident was at risk for falls and a RPN, RN, and the Physiotherapist (PT) indicated that one of the falls prevention interventions for the resident was to ensure a device was within their reach.

This intervention was not documented in the resident's care plan.

On one occasion, the resident had a fall outside of their bedroom. Prior to the fall, a PSW assisted the resident to sit in a chair, inside their room. When asked by the inspector if the device was within the resident's reach where they were located prior to the fall, the PSW stated the device was not within the resident's reach.

By not documenting the intervention, there was potential for staff to not consistently ensure that the device was within the resident's reach.

Sources: Resident's care plan; Interviews with RPN, RN, PSW, the PT, and the ADOC. [653]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that a post-fall assessment was conducted when a resident sustained a fall in the home.

Rationale and Summary

A resident started to slide down from their bed. A PSW pulled the call bell, and a second PSW came and both of them slowly assisted the resident to the floor.

The two PSWs did not immediately report to the RPN that the resident ended up on the floor. Without notifying the RPN, the two PSWs transferred the resident with a mechanical lift, from the floor to the bed.

The resident did not receive a post-fall assessment at the time of the incident.

The ADOCs indicated that the incident was considered as an assisted fall, and that a post-fall assessment should have been conducted by the registered staff.

By not conducting a post-fall assessment, there was a risk that potential injuries were not identified and addressed.

Sources: Resident's progress notes, assessments, the home's Falls Prevention & Management policy #VII-G-30.10; Interviews with the PSW, RPN, and the ADOCs. [653]