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

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Original Public Report

Report Issue Date: April 14, 2023	
Inspection Number: 2023-1372-0006	
Inspection Type: Complaint Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Hawthorn Woods Care Community, Brampton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature** Daniela Lupu Digitally signed by Daniela Lupu Date: 2023.04.28 10:49:30 -04'00'
Additional Inspector(s) Amanpreet Kaur Malhi (741128)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 14-16, 21-24, 27-31, and April 3, 2023.

The following intake(s) were inspected:

·Intake #00003311, and #00022676, related to injuries of unknown cause
·Intake #00007090, related to an injury and significant change in health status
·Intake #00015177, #00016769, and #00017755, related to abuse and neglect
·Intake #00017088, related to a complaint regarding falls prevention, and resident care
·Intake #00017089, related to falls prevention and management.

The following intakes were reviewed during this inspection:

Intake #00002286, #00003624, #00008141, #00012751, #00015878, #00016085, #00016087, and #00016187, related to falls prevention and management.

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

Resident Care and Support Services

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 plan of care related to falls prevention was provided to the resident as specified in the plan.

Rationale and Summary

A resident was at risk for falls and had specific falls interventions in their plan of care.

A Registered Nurse (RN) responded to a resident's call bell and witnessed them falling while they were not using their assistive device.

A Personal Support Worker (PSW) said they did not implement one of the falls prevention interventions as per the resident's plan of care.

The DOC said staff should have followed falls prevention interventions as indicated in the resident's plan of care.

By not ensuring the falls intervention was in place, staff could not intervene to mitigate the risk for falls.

Sources: a critical incident report, a resident's clinical records, and interviews with PSWs, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from abuse by another resident.

Section 2 (1) (c), of the Ontario Regulation 246/22 defines physical abuse as, "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary:

A resident caused an injury to another resident who came into their personal space.

Sources: a critical incident report, a resident's clinical records, interview with two RPNs.
[741128]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the home carried out the policy directive for case and outbreak management during a COVID-19 outbreak.

In accordance with the Minister's Directive, COVID-19 Response Measures for Long-Term Care Homes, effective August 30, 2022, issued under the Fixing Long-Term Care Act, 2021, the licensee was required to ensure that case and outbreak management requirements were followed as set out in the Ministry of Health COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective December 23, 2022.

Rationale and Summary

The Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, effective December 23, 2022, section four, documented licensees should follow the requirements for case and outbreak management as set out in the COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units Version 9, January 18, 2023.

The COVID-19 Guidance Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units effective June 27, 2022, and updated on January 18, 2023, documented that during a suspected or confirmed outbreak, homes should continue to conduct enhanced symptom

assessment minimum twice daily of all residents in the outbreak area to facilitate early identification and management of ill residents.

The home's COVID-19 Prevention and Management policy documented that during a suspected or confirmed outbreak, registered staff were to conduct enhanced system assessments minimum twice daily using the Point Click Care (PCC) Resident Daily Active Screener for early detection of symptoms and the PCC Daily Health Assessment for ill residents.

A COVID-19 outbreak was declared at the home by Public Health.

Two residents resided in the same room in one of the Resident Home Areas (RHAs) which was on COVID-19 outbreak.

i) On multiple occasions, the two residents' daily active screener assessments were not completed twice daily as required.

ii) One of these two residents was symptomatic and placed on Droplet and Contact Precautions. On two separate occasions the resident's daily health assessments were not completed twice daily.

The home's IPAC Lead/ADOC said that the enhanced assessments for the residents in the outbreak area should have been completed twice daily as required.

By not completing the enhanced symptom assessments at minimum twice daily for all the residents in the outbreak area, there was a risk that symptoms of infection were not identified and managed in a timely manner.

Sources: two residents' clinical records, a critical incident, the Minister's Directive, COVID-19 Response Measures for Long-Term Care Homes, effective (August 30, 2022), COVID-19 Guidance Document for Long-Term Care Homes (LTCHs) in Ontario, (December 23, 2022) , The COVID-19 Guidance Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (January 18, 2023), home's policy Novel Coronavirus – COVID-19 Prevention & Management (February 2023), and interviews with an RPN and the home's IPAC Lead/ADOC [758]

WRITTEN NOTIFICATION: Bed Rails

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

The licensee has failed to ensure that where the bed rails were used, a resident was assessed to

minimize the risk of harm to the resident.

Rationale and Summary

A resident needed assistance from staff members for bed mobility and transfers.

Upon the resident's admission, the home's Occupational Therapist (OT) recommended the use of two bed rails for bed mobility.

The home's bed rails policy, documented nurses would ensure that resident safety was monitored upon admission for entrapment risks and as per assigned task to the PSW and Resident Care Aide. Additionally, nurses and the physiotherapist (PT) or OT were to complete in collaboration the Electronic Bed Rail Assessment in Point Click Care (PCC).

The resident's bed safety sleep observations were completed for nine nights. There were no bed safety assessments completed by nurses after the bed safety sleeping observations were finished or after the resident used two bed rails. The PT/OT's section of the bed safety assessment was not completed until approximately two weeks after the bed safety observations were completed.

An RPN and the DOC said the bed safety assessment should have been completed after the sleep observations period to determine any safety concerns related to the use of bed rails. They also said a new assessment should have been completed when there was a change in the number of the bed rails used.

By staff not assessing the resident for the use of bed rails, it increased the risk of harm to the resident.

Sources: a resident's clinical records, the home's bed rails policy, and interviews with an RPN, the DOC and other staff. [758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #005 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 actions taken with respect to two residents under a program, including interventions, and the residents' response to the interventions, were documented.

Rationale and Summary

A. A resident was at risk for falls due to their medical condition and a history of falls.

i) Multiple staff members said that one of the falls prevention interventions was to ensure that a certain item was in place for the resident. This intervention was not documented in the resident's plan of care for approximately three months and at the time of this inspection.

The home's Falls Lead/ADOC said that the intervention should have been documented in the plan of care since the resident always used the specific falls prevention item.

By not documenting a falls prevention intervention in the resident's plan of care, there was potential for staff to not consistently ensure the intervention was in place.

ii) A resident's falls prevention strategies included a falls intervention at specific time intervals and ensuring that the resident's devices for falls prevention were properly placed. These interventions were to be documented in the resident's Point of Care (POC).

In a two-month period, on separate dates and times, the documentation of the falls intervention was missed. Additionally, on multiple occasions, the documentation regarding the resident's falls prevention devices was missed.

The home's Falls Lead/ADOC said that the interventions should have been documented as specified in the resident's plan of care.

By not documenting the specific falls prevention interventions, made it difficult to evaluate the effectiveness of these interventions.

Sources: a resident's clinical records and interviews with a PSW, RPN, RN, the home's Falls Lead/ADOC and the DOC. [758]

B. A resident required assistance from one staff member for oral care.

On one occasion, the resident's caregiver reported to an RPN concerns related to the resident's oral condition.

The RPN said they directed staff to monitor the resident for any concerns related to oral care and eating abilities and indicated that no concerns were identified. There was no documentation of these interventions and the resident's response in the resident's plan of care.

The DOC said that the interventions provided and the resident's responses should have been documented.

By not documenting the interventions provided to the resident, other team members may not be aware of the concerns and would not be able to take appropriate actions if needed.

Sources: a resident's clinical records, and interviews with an RPN, the DOC and other staff. [758]

C. A resident was at risk for falls due to their history of falls and being newly admitted to the home.

i) Upon the resident's admission, the physiotherapist made multiple recommendations for falls and injury prevention.

The resident's plan of care did not include any information related to two of the falls and injury prevention interventions.

An RPN said these two interventions were implemented for the resident.

The DOC said that the falls prevention interventions should have been documented in the plan of care as required.

By not documenting the falls prevention interventions in the resident's plan of care, there was potential for staff to not consistently provide these interventions to the resident.

Sources: a resident's clinical records, and interviews with an RPN, the DOC and other staff.

ii) A resident required bed rails for bed mobility and assisted transfers.

Multiple staff members said the resident used the bed rails to turn and reposition in bed and during transfers. An RPN said the resident used the bed rails as a Personal Assistive Support Device (PASD).

The home's policy related to the use of PASD, documented that interventions in the resident plan of care should include detailed information about the PASD use, including how, when and how long the PASD would be used, who would apply and remove the PASD, the frequency of monitoring, and the removal of the PASD as soon as it was no longer required to provide the resident with the specific routine of daily living intended for use, and any specific risks associated with the use of PASD.

The resident's plan of care did not include any information about the use of the bed rails as a PASD.

The DOC said information related to the use of bed rails as a PASD should have been included in the resident's plan of care as indicated in the home's policy.

By not documenting the interventions related to use of bed rails in the resident's plan of care, there was potential risk that staff would not consistently apply and monitor the resident when the bed rails were used.

Sources: a resident's clinical records, the home's PASD policy, and interviews with PSWs, an RPN the DOC, PT and OT. [758]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that two PSWs used safe transferring techniques when they assisted a resident with a transfer.

Rationale and Summary

A resident required assistance from two staff members with transfers and toileting task using a mechanical device.

On one occasion, during a transfer, the resident attempted to remove their hand from the device before staff completed their care. The two PSWs continued with the care and held the resident's hand to prevent them from removing it from the mechanical device.

The DOC said staff members should have maintained the resident's safety during the transfer by lowering the resident to a safer surface and re-approach the resident at a later time for care.

The resident sustained an injury after this interaction with the two staff members.

Sources: a resident's clinical records and interviews with PSWs, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #007 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 incontinent of bladder and bowel. Following a change in their condition, the resident had a deterioration of their bladder and bowel continence status.

A monitoring tool was initiated to track and identify the resident's continence patterns and the use of the appropriate continence product.

A PSW said the resident did not have an individualized toileting schedule in place before or immediately after the change in their condition.

An RPN said after completing the continence monitoring tool, a bowel and bladder continence assessment should be completed, and an individualized toileting plan should be implemented.

A bowel and bladder continence assessment was not completed and an individualized continence plan of care was not implemented until approximately one month after the resident's change in condition.

By not having an individualized toileting plan, a consistent routine could not have been established, which increased the risk of the resident attempting to go to the washroom without staff assistance.

Sources: a resident's clinical records and interviews with a PSW, RPNs and the DOC. [758]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that strategies to respond to a resident's responsive behaviours, were implemented.

Rationale and Summary

A resident had multiple responsive behaviours and had strategies in their plan of care to de-escalate their behaviours.

On one occasion, while two PSWs were providing the resident with care, the resident displayed responsive behaviours towards one of the PSWs and attempted to remove their own hand from a transferring device. One of the PSWs used a strategy that was not aligned with the resident's plan of care when trying to manage their responsive behaviours.

Shortly after this interaction, the resident was observed with an injury.

The DOC said staff should have maintained the resident's and their own safety. They also said if the resident was exhibiting responsive behaviours, staff should have used the strategies identified in the resident's plan of care.

Not implementing the strategies to respond to the resident's responsive behaviours as outlined in the resident 's plan of care resulted in the resident's injury.

Sources: a critical incident report, a resident's clinical records, the home's investigative notes and interviews with PSWs, RPNs, and the DOC. [758]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #009 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

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 6.1 indicates the licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and residents, including having a PPE supply in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions.

The home's policy related to the provision of care for a resident with probable COVID-19, documented that when caring for a probable case of COVID-19, staff should set up the PPE equipment at entry to the resident's room.

A resident was on Droplet and Contact Precautions and their PCR test results were pending.

Public Health Ontario (PHO) Droplet and Contact signage was posted on the resident's room door. The signage directed staff and visitors to wear a mask and eye protection when within two meters of the resident and to wear a gown and gloves when providing direct resident care.

On two separate occasions, there was no eye protection and one occasion there were no gowns in the PPE container placed by the entrance of the resident's room.

The home's IPAC Lead/ADOC said all required PPE, including masks, eye protection, gowns and gloves should be available by the entrance of the resident's room where droplet contact precautions were in place even if the home area was not on COVID-19 outbreak.

By not having PPE available at the point of care when Additional Precautions were in place, there was potential risk that staff and visitors would not wear the required PPE when providing direct care or being within two meters of the resident suspected for COVID-19.

Sources: observations of PPE availability at Point of Care, PHO Droplet and Contact Signage, a resident's clinical records, IPAC Standard (April 2022), and interviews with one PSW, RPNs and the home's ADOC/IPAC Lead. [758]