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 District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: June 20, 2024
Inspection Number: 2024-1372-0002
Inspection Type: Proactive Compliance Inspection
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Hawthorn Woods Community, Brampton

Lead Inspector	**Inspector Digital Signature**
Gurvarinder Brar (000687)	Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2024.07.10 14:25:24 -04'00'

Additional Inspector(s)
Nuzhat Uddin (532)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15-17, 21-24, & 27-31, 2024

The following intake(s) were inspected:

- Intake: #00115188 -Proactive Compliance Inspection (PCI).

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management

Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 22.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences and age-related needs and preferences.

The licensee failed to ensure a plan of care was based on, at a minimum, interdisciplinary assessment with respect to the resident's Cultural, spiritual and religious preferences and age-related needs and preferences.

Rationale and Summary
An Registered Practical Nurse (RPN) stated residents cultural food preferences should be documented in their care plan and food preferences are documented by the Registered Dietitian (RD).

A resident said they preferred food based on their cultural preferences.

The resident's plan of care did not include the resident's preferences of food.

The RD stated they were not aware that the resident preferred food from the specific culture.

Failure to assess the resident based on their cultural preferences means the staff may not consider the residents preferences when serving food to them.

Sources: Residents Clinical Record; Interviews with Resident, RPN, RD and other staff. [000687]

WRITTEN NOTIFICATION: Menu Planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that a planned menu item was offered and available at each meal.

Rationale and Summary
During the lunch meal observation a planned menu item was not offered to the residents.

The Dietary Manager indicated that the expectation was for the staff to offer the planned menu item.

By not offering the planned menu item, the residents were not provided an opportunity to make their own choice of having the planned menu item during the lunch meal service.

Sources: The home's menu cycle; Inspector #000687 lunch meal observation; Interviews with Dietary Manager and other staff. [000687]

WRITTEN NOTIFICATION: Dining and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee failed to follow their process for ensuring that food being served was at a temperature that is both safe and palatable to the residents.

Rationale and Summary
According to the Food Service Manual, "No more than 15 minutes prior to serving, the food service worker take the temperature of all food items and records on temperature sheet"

During the record review, there were missing temperature documentation for two of the items which were served during lunch.

The Dietary Manager stated that dietary aids were expected to check and document the temperature of the items before they started serving them to the residents.

Failure to check and document the temperature of food items means staff were not aware of whether the temperature was not safe or palatable for residents.

Sources: Review of temperature log and Food Service Manual; and interview with Dietary Aid, Dietary Manager and other staff. [000687]

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

The license has failed to ensure that procedures were implemented for cleaning and disinfection of the resident care equipment, such as tubs, shower chairs and lift chairs.

Staff did not comply with the home's policy, "Equipment Cleaning – Resident Care & Medical, IX-G-20.90", dated March 2024. Specifically, the policy directed staff to clean the tub chair/shower chair and commodes and disinfect them after each resident's use using a designated disinfectant for tubs, a hospital grade high level disinfectant (i.e., ED, 1492, Virox, Accel Intervention, Fuzion, Saber, etc.) and follow directions for use.

The policy further stated lifts were to be thoroughly cleaned and disinfected on a weekly schedule or more frequently if soiled, and high touch areas of the lifts were to be disinfected between each resident use.

Rationale and Summary
During observation bathtubs and shower rooms were noted to be of concern. There was no specified disinfection in any of the tub rooms, one of the shower rooms had no disinfectant, and the remaining shower rooms contained expired Pre-empt ready-to-use (RTU) disinfectant.

The Hoyer lifts and sit-to-stand lift lacked disinfectant wipes and were covered with dirt and debris.

The PSWs acknowledged that the tubs did not have the designated disinfectant, shower room disinfectant had expired and the lifts did not have the disinfectant wipes attach to them.

Infection and Prevention Control Lead (IPAC) Lead stated that all tub rooms and shower rooms should be cleaned and disinfected after each use by nursing team member. The housekeeping staff were also supposed to follow a cleaning and disinfecting schedule of these items as assigned.

The residents' risk of infection transmission increased when shared care equipment was not cleaned and disinfected in between uses.

Sources: Observations, policy review Equipment Cleaning – Resident Care & Medical, IX-G-20.90 and interview with the PSWs and the IPAC lead. [532]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the additional requirements under Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023 were followed.

Specifically, additional requirement under 9.1 the IPAC Standard states that the licensee shall ensure that hand hygiene, including, but not limited to, at the four moments of hand hygiene before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact) were followed.

Rationale and Summary
The home's policy, "Hand Hygiene, IX-G-10.10" policy dated November 2023, stated that all team members and volunteers will practice hand hygiene to reduce the spread of infection. Hand hygiene consists of either hand washing or the use of alcohol-based hand rub (ABHR). Specifically, before donning gloves, after doffing gloves, before entering a resident's room and before exiting a resident's room.

Personal Support Worker (PSW) was observed not practicing hand hygiene (HH) after leaving a resident's room and before entering into another resident's room and

carried the soiled bag from one resident's room to another.

The PSW acknowledged that they should have performed HH before entering another room and should not have carried a soiled bag to another residents room.

The IPAC lead confirmed that staff were supposed to perform HH before donning gloves, after doffing gloves, before entering a resident's room and before exiting a resident's room. The IPAC lead stated they should not have carried the soiled bag to different rooms.

There was potential risk to residents when staff did not perform hand hygiene after doffing gloves, and carried a soiled bag to different rooms, which could have led to the spread of potentially harmful pathogens and infection.

Sources: Hand Hygiene, IX-G-10.10" policy dated November 2023, record review for resident, observations dated, interview with PSW and the IPAC lead. [532]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (1)
Continuous quality improvement committee
s. 166 (1) Every licensee of a long-term care home shall establish a continuous quality improvement committee.

The licensee failed to establish a continuous quality improvement committee.

Rationale and Summary
The Executive Director acknowledged that there is no continuous quality improvement committee established in the home.

Failure to not have continuous quality improvement committee was a missed opportunity for licensee to the implement CQI initiative.

Sources: Record review of Leadership and Quality meeting minutes and Interviews with ED and DOC. [000687].