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
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Original Public Report

Report Issue Date: November 18, 2024

Inspection Number: 2024-1372-0003

Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Hawthorn Woods Community, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 23- 25, 28- 31, 2024, and November 1, and 4-5, 2024.
The inspection occurred offsite on the following dates: November 6, 7, 2024

The following intakes were inspected:
• Intake #00123274, #00124038, and #00123467, related to alleged abuse
• Intake #00123890, related to a respiratory outbreak.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented.

Rationale and Summary

A resident was provided with an intervention that was not documented in their plan of care.

The resident's plan of care was updated to include the above information on November 5, 2024.

Sources: observations of a resident's room, a resident's plan of care, and interviews with the Behavioural Support Ontario (BSO) Lead and an Associate Director of Care (ADOC).

Date Remedy Implemented: November 5, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed, and care set out in the plan was no longer necessary.

Rationale and Summary

A resident's plan of care included information that was not current and no longer necessary.

On November 5, 2024, the resident's plan of care was revised to reflect the updated information.

Sources: a resident's clinical records, and an interview with an ADOC.

Date Remedy Implemented: November 5, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record of a complaint related to a resident's care and alleging harm to the resident was kept at the home.

Rationale and Summary

A complaint related to a resident's care alleging harm to the resident was received by the home, however the complaint record was not completed as required.

Sources: a critical incident report, the home's complaint records and an interview with the Director of Care (DOC).

Date Remedy Implemented: November 4, 2024

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure a resident's plan of care related to responsive behaviours set out clear directions to staff and others who provided direct care to

the resident.

Rationale and Summary

A resident's plan of care directed staff to implement an intervention to prevent the resident's responsive behaviours.

Multiple staff were unclear when and how often this intervention should have been implemented.

An incident occurred when the resident had responsive behaviours which caused an injury to another resident.

An ADOC acknowledged that the plan of care did not include clear directions to staff, as required.

By not ensuring that the resident's plan of care included clear directions, staff provided the intervention inconsistently and could not intervene in a timely manner to prevent the resident's responsive behaviours.

Sources: a critical incident report, resident's clinical records and interviews with Personal Support Workers (PSW), Registered Practical Nurses, BSO Lead and an ADOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive

behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

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

Rationale and Summary

A resident's plan of care documented specific strategies for staff to respond to the resident's responsive behaviours.

An incident occurred when staff did not implement these strategies. As a result, the resident's responsive behaviour escalated, and the resident sustained an injury.

An ADOC and the DOC said staff should have followed the strategies to respond to the resident's responsive behaviours as indicated in their plan of care.

Staff not implementing the strategies to respond to the resident's responsive behaviours contributed to the resident's injury.

Sources: a critical incident report, a resident's clinical records, the home's investigation notes and interviews PSWs, an RPN, an ADOC and the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 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 that the Infection Prevention and Control (IPAC) Standard issued by the Director was followed by staff.

Rationale and Summary

A. According to the additional requirement under section 9.1 of the IPAC Standard, 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.

During a meal service on one of resident home areas, a staff did not perform hand hygiene according to the four moments of hand hygiene.

The IPAC Lead said staff should have followed the hand hygiene practices, as required.

By not performing hand hygiene as required, there was an increased risk of microorganisms transmission among the residents and staff.

Sources: a meal observation, the home's Hand Hygiene policy and Interviews with staff.

B. According to the additional requirement under section 10.2 (c) of the IPAC Standard, the hand hygiene program shall include assistance to residents to perform hand hygiene before meals and snacks.

On one occasion, multiple residents were not offered hand hygiene before being served their snacks.

The IPAC Lead stated that staff were expected to offer hand hygiene for the residents prior to serving snacks.

By not offering hand hygiene to the residents, there was an increased risk of microorganisms transmission among the residents and staff.

Sources: an observation of snack service, the home's Hand Hygiene policy and interviews with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The licensee has failed to ensure that when the investigation of a complaint alleging harm to a resident was not completed within 10 business days of the receipt of the complaint, an acknowledgment to include the date by which the complainant could

reasonably expect a resolution was provided to the person who made the complaint.

Rationale and Summary

A complaint as described in NC #003 was received by the home.

Despite the investigation of the complaint not being completed within 10 business days of the receipt of the complaint, the person who made the complaint was not provided an acknowledgment to include the date by which they should expect a resolution.

The DOC acknowledged gaps in the communication with the complainant.

By not providing the complainant with the information related to the expected date of the resolution of their complaint, they were unaware of the delays and remained dissatisfied with the home's communication process.

Sources: a critical incident report, a resident's clinical records, the home's complaint record, and an interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response to the person who made a complaint related to a resident's care included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

A complaint as described in NC #003 was received by the home.

The response provided to the person who made the complaint did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and the contact information for the patient ombudsman.

The DOC acknowledged that the response to the person who made the complaint did not include the above information as required.

By not providing the required information, it limited the complainant's ability to know their options.

Sources: a critical incident report, a resident's clinical records, the home's complaint record, and an interview with the DOC.