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

Public Report

Report Issue Date: February 13, 2025

Inspection Number: 2025-1372-0001

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

This is a modified Public Inspection Report. The following changes have been made:
-Written Notification (NC #001) - removal of Personal Health Information.
-Compliance Order #001 (NC #011) - summarization of Grounds section and removal of Personal Health Information.

The inspection occurred onsite on the following date(s): January 21-24, 27-31, 2025 and February 3-7, and 11, 2025.

The following intake(s) were inspected:

- Intake: #00129823 - complaint related to resident care concerns.
- Intake: #00132488 - resident injury resulting in hospital transfer.
- Intake: #00133438 - resident to resident alleged abuse.
- Intake: #00134105 - resident to resident alleged abuse.
- Intake: #00134260 - unwitnessed fall of a resident.
- Intake: #00136700 - disease outbreak.

The following intake(s) were completed in this inspection:

- Intake: #00136704 - disease outbreak.
- Intake: #00136998 - unwitnessed fall of a resident.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure a resident was protected from physical and emotional abuse by their roommate.

Ontario Regulation 246/22 section 2 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

It further defines emotional abuse as "any threatening or intimidating gestures,

actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences."

On five separate occasions, a resident was noted by staff to be verbally responsive towards another resident.

A separate occasion occurred where the co-resident approached the resident and was physically expressive towards them. As a result, the resident sustained an injury.

Sources: Record review of Critical Incident (CI) report, internal investigation notes from the home; and interviews with staff.

WRITTEN NOTIFICATION: Complaints procedure - Licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure a complaint concerning the care of a resident was forwarded to the Director. The complaints from 2024 included concerns with the resident's skin and wound care, as well as infection prevention and control.

Sources: Record review of Complaint Record Forms; and interviews with multiple

members of the home's management team.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

A resident was identified to be positioned unsafely in their wheelchair when being assisted by a staff member. As a result, the resident sustained an injury.

Sources: Record review of the resident's progress notes and Critical Incident (CI) Report; and interviews with staff in the home.

WRITTEN NOTIFICATION: Notification re personal belongings

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 42 (a)
Notification re personal belongings, etc.
s. 42. Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or

The licensee failed to ensure a resident's substitute decision makers were notified when the resident's toothbrush had significant debris, and required replacement.

Sources: Record review of a resident clinical records; correspondence with Powers of Attorneys (POAs), and an interview with Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure residents with a specific infection in their skin were initially assessed using a clinically appropriate skin assessment instrument.

A) The licensee failed to ensure a resident's infections were assessed using a clinically appropriate assessment instrument when they were initially identified.

Sources: Record review of a resident's clinical records, and Skin & Wound Care Management Protocol VII-G-10.90 (Policy ID# 16123469, last revised July 2024); and interviews with staff.

B) The licensee failed to ensure a resident received an assessment with a clinically appropriate skin assessment instrument when they were first identified to have an

infection.

Sources: Record review of a resident's clinical records and Skin & Wound Care Management Protocol VII-G-10.90 (Policy ID# 16123469, last revised July 2024).

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure a resident received treatment for a specific infection on several different areas during a two month period.

Sources: Interviews with the Physician as well as other staff; record review of a resident's clinical records.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1 (f) under the IPAC standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure staff donned Personal Protective Equipment (PPE) in accordance with Additional Precautions.

The licensee failed to ensure a Personal Support Worker (PSW) and a housekeeper donned face protection in accordance with additional droplet and contact precautions on January 28, 2025. The staff were observed without a face shield or goggles while they were within two meters of the room occupants.

Sources: Inspector observations; record review of the IPAC Standard (September 2023); and an interview with ADOC-IPAC Lead.

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 failed to ensure their response to persons who made complaints regarding a resident's care in 2024 received a response that included the Ministry's toll-free telephone number for making complaints about homes, its hours of service, and contact information for the Patient Ombudsman under the Excellent Care for All Act, 2010.

Sources: Record review of Complaints Management Program (Policy ID 15945243, last revised June 2024), and complaint records; and interviews with the Assistant Director of Care (ADOC) and Executive Director (ED).

WRITTEN NOTIFICATION: Dealing with complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 failed to ensure a written record was maintained of each verbal or written complaint from a resident's Powers of Attorneys (POAs) regarding improper care of the resident was maintained in accordance with requirements of Ontario

Regulation 246/22 s. 108 (2), and the licensee's internal policy for managing complaints. This included allegations of staff not supervising the resident in alignment with their falls prevention and management intervention, as well as continence care concerns.

Sources: Record review of 2024 Complaint record forms, resident's clinical records, and Complaints Management Program (Policy ID 15945243, last revised June 2024); and interviews with ADOCs.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee failed to ensure that the Director was informed no later than three business days of the incident involving a resident's injury and transfer to the hospital, resulting in a significant change in their health condition.

Sources: Record review of Critical Incident (CI) Report; and interview with Director of Care (DOC).

COMPLIANCE ORDER CO #001 Altercations and other interactions between residents

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.1
Non-compliance with: O. Reg. 246/22, s. 59
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Educate all registered staff on the home's process for responding to a resident's behavioural expressions that pose a risk of physical or emotional harm to other residents. Ensure the education includes:
(a) Procedures for registered staff to investigate suspected resident abuse if it is identified during a DOS monitoring period.
(b) Procedures for registered staff documentation to support identification of factors that could potentially trigger altercations between residents.

2.The education shall be performed by a member of the home's management team.

3.Maintain a record of the education, including the date and contents of the

education, the staff who attended, and the staff who presented.

Grounds
The licensee failed to ensure steps were taken to minimize the risk of altercations between resident and other co-residents.

The home's policy for Resident's Behaviours Management directed nursing staff to initiate Dementia Observation System (DOS) monitoring, as well as a Behavioural Assessment and Referral, when residents were exhibiting responsive behaviours, including changes or worsening of responsive behaviours.

A resident was physically and/or verbally expressive towards other residents on multiple occasions. Interventions were not identified and/or implemented to minimize the risk of altercations between the resident and their co-residents.

Multiple residents were at increased risk of altercations when strategies were not implemented appropriately, to respond to the changes of the resident's responsive behaviours during a three month period.

Sources: Record review of the home's Responsive Behaviour Management Policy (Policy ID 16824816, Last revised October 2024), Critical Incident (CI) reports, and residents' clinical records; and interviews with staff.

This order must be complied with by March 25, 2025.

COMPLIANCE ORDER CO #002 Skin and wound care

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Educate all registered staff on the home's policies relevant to skin and wound assessment, including procedures for identifying, assessing, monitoring, and seeking treatment for a specific infection. A record will be maintained of the education provided, who received the education, date(s) of when the education was provided, as well as the contents of the education and training materials.

2.Following the education, conduct an audit of weekly skin and wound assessment for a specific infection.
(a) The audit will be conducted by a member of the home's management, or clinical leadership team.
(b) It will be conducted daily over a four-week period. If no residents have been suspected or diagnosed with the specified infection at the time of the audit, review the weekly skin and wound assessments of a resident from each unit of the home with impaired skin integrity.
(c) The audit will review the weekly skin assessments for completeness and whether appropriate actions were taken when there were changes to the identified skin concern.
(d) Maintain a record of the audits completed, name of the person who completing them, dates of when the audits were completed, and a list of which residents were involved in the audit.
(e) Maintain a record of any action taken when non-compliance is identified, including the dates the corrective actions were taken.
(f) Analyze the results of the audits, address any concerns identified, and document

the corrective actions taken.

Grounds
The licensee failed to ensure residents received weekly reassessments using a clinically appropriate assessment instrument for a specific skin infection.

A) The licensee failed to ensure a resident received assessments using a clinically appropriate tool for a specific infection in a three month period.

The infection prevention and control monitoring documentation did not consistently indicate which location of the skin infection that was being monitored, including when an infection involved redness, swelling, pus, and discharge.

There were no clinical assessment instruments used to determine whether the areas were improving, worsening, or changing. Multiple physician assessments that resulted in treatment changes were initiated by a POA and not registered staff.

The lack of assessments with the home's clinically appropriate instrument may have contributed to treatment gaps for the specified skin infections.

Sources: Record review of a resident's clinical records, Skin & Wound Care Management Protocol VII-G-10.90 (Policy ID# 16123469, last revised July 2024), Interviews with the home's Skin and Wound Lead, as well as other staff.

B) The licensee failed to ensure a resident received weekly reassessment of a specific infection using the home's clinical assessment tool during a two month period.

A member of the home's management team stated the home had not been using the home's clinical skin and wound assessment instrument for monitoring the residents' specific infections throughout the home until the concern was identified

during the inspection.

When the residents' infections were not reassessed weekly using a clinically appropriate assessment instrument, they were at increased risk of ineffective care and delayed treatment.

Sources: Record review of a resident's clinical records, the home's Skin & Wound Care Management Protocol VII-G-10.90 (Policy ID# 16123469, last revised July 2024); Interview with a member of the home's management team.

This order must be complied with by April 30, 2025.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

O.REG. 246/22 s. 55 (2)(b)(iv)

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

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
e-mail: 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.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.