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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Public Report

Report Issue Date: April 11, 2025

Inspection Number: 2025-1372-0002

Inspection Type:
Critical Incident
Follow up

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 date(s): April 1-4, 10-11, 2025.

The following intake(s) were inspected:

- Intake: #00139885, follow-up order #001 related to responsive behaviours
- Intake: #00136857, related to prevention of abuse and neglect.
- Intake: #00138987, related to resident care and support services.
- Intake: #00139533, related to resident care and support services.
- Intake: #00142074, related to fall prevention and management.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1372-0001 related to O. Reg. 246/22, s. 59

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
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in a resident's plan of care was provided to that resident as specified in their plan.

The resident required assistance with two staff for toileting. A Personal Support Worker (PSW) assisted the resident to the washroom without a second a staff member present and the resident experienced an assisted fall.

Sources: Critical Incident System (CIS) report, a resident's clinical records, the home's investigation notes; Interviews with a PSW, and the Director of Care (DOC).

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with, when a resident's substitute decision maker (SDM) reported an allegation of neglect to the Associate Director of Care (ADOC).

Specifically, the home's policy outlined that multiple actions are to be taken by staff when an allegation of neglect is received. These procedural steps did not occur for the resident.

Sources: A CIS Report, a resident's clinical records, Prevention of Abuse & Neglect of a Resident policy #VII-G-10.00, Interviews with the ADOC, the DOC, and other staff.

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

The resident's clinical records indicated that the resident required a specific lift for transfers with assistance from two team members. The resident was transferred to the washroom using an incorrect lift by one PSW and whilst on the toilet attached to the lift, the PSW left the resident alone and unsupervised for a period of time.

Sources: A resident's clinical records, CIS Report, The home's investigation notes, the home's zero lift policy, and interview with the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee failed to ensure that the resident who was dependent on staff for repositioning, was repositioned every two hours or more frequently as required.

The resident had an area of altered skin integrity and was not turned and repositioned by staff on a specific date.

Sources: CIS Report, a resident's written plan of care; Interviews with the ADOC and other staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee failed to ensure that resident's individualized plan to promote and manage bowel and bladder continence, was implemented.

The resident required staff assistance for toileting and continence care. The resident did not receive continence care when they needed to be changed on a specific date.

Sources: CIS Report, the resident's clinical records, the home's internal investigation notes; Interviews with the ADOC, and other staff.