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: July 31, 2025

Inspection Number: 2025-1372-0004

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: July 22-24, 28-31, 2025.

The following Complaint intakes were inspected:
· Intakes: #00148591 and #00149141 related to an allegation of abuse and resident care and support services.

The following Critical Incident (CI) intakes were inspected:
· Intake: #00148599 related to an allegation of abuse.
· Intake: #00149195 related to resident care and support services.
· Intake: #00153389 related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Responsive Behaviours

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Reporting and Complaints
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 written plan of care was provided to the resident as specified in the plan, specifically, a medical procedure was not completed as ordered by a physician.

Sources: Resident's clinical health records; the home's internal investigation notes; Interviews with the Director of Care and other staff.

WRITTEN NOTIFICATION: Personal care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36
Personal care
s. 36. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

The licensee failed to ensure that a resident received individualized personal care, including hygiene care and grooming, specifically, the required staff assistance.

Sources: Resident's clinical health records; Inspector's observation; Interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that their falls prevention and management program provided strategies to reduce or mitigate falls for a resident, including the monitoring, and the use of equipment, supplies, devices and assistive aids.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Registered staff were required to evaluate the effectiveness of fall prevention interventions on an ongoing basis and update the resident's plan of care with resident specific interventions with any fall. PSWs were to use fall prevention

interventions identified on the resident's plan of care. These were not done for a resident.

Sources: Resident's clinical health records, Falls Prevention & Management Policy and Procedure, the home's internal investigation; Interview with the falls lead and other staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that the monitoring of a resident's behaviours using a clinical tool, was fully documented.

Sources: Resident's clinical health records, Responsive Behaviours Management Policy last revised 10/2024; Interviews with the Behavioural Support Ontario (BSO) Nurse, and other staff.