Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
May 28, 2019	2019_791739_0014	008922-18, 011290-18, 014696-18, 018000-18, 018028-18, 020481-18, 026333-18, 026344-18, 027192-18, 031173-18	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Hawthorn Woods Care Community
9257 Goreway Drive BRAMPTON ON L6P 0N5

Name of Inspector(s)/Nom de l’inspecteur ou des inspecteurs

JULIE DALESSANDRO (739), CHERYL MCFADDEN (745), MEAGAN MCGREGOR (721), TERRI DALY (115)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 21, 22, 23, and 24, 2019.

Related to Abuse and Neglect:
Log #008922-18 / CI #2887-000015-18
Log #011290-18 / CI #2887-000017-18
Log #018000-18 / CI #2887-000024-18
Log #018028-18 / CI #2887-000026-18
Log #020481-18 / CI #2887-000030-18
Log #026344-18 / CI #2887-000037-18
Log #026333-18 / CI #2887-000038-18
Log #027192-18 / CI #2887-000040-18
Log #031173-18 / CI #2887-000047-18

Related to Falls Prevention and Management:
Log #014696-18 / CI #2887-000020-18

During the course of the inspection, the inspector(s) spoke with Personal Support Worker(s), Registered Practical Nurse(s), Registered Nurse(s), Assistant Director(s) of Nursing, Director of Nursing, and the General Manager.

During the course of this inspection the inspector(s) also completed observations and record reviews relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

The home submitted Critical Incident System (CIS) report #2887-000015-18/Log #008922-18 to the Ministry of Health and Long-Term Care (MOHLTC), related to a physical altercation between resident #001 and #002 on a specific date. The CIS report stated that following the incident on that date, specific safety interventions were in place for resident #002 until a different date, at which point the safety interventions were tapered and discontinued.

Resident #002's clinical record was reviewed in Point Click Care (PCC) and included an incident report dated the same day as the incident, which stated that after the physical altercation had occurred between resident #001 and resident #002 that day, safety interventions were put in place for both residents. Resident #002's Care Plan and Kardex did not identify that these specific safety interventions were to be in place for this resident.

During an interview with Inspector #721, when asked how they would know what type of care should be provided for a resident with responsive behaviours, Personal Support Worker (PSW) #106 stated that they would look at a residents Kardex or ask a senior staff member for this information. PSW #106 told Inspector #721 that they did not have access to view resident's progress notes.

During an interview with Inspector #721, when asked how they would know what type of

care should be provided for a resident with responsive behaviours, Registered Nurse (RN) #107 stated that if a resident had ongoing behaviours it would be documented in their Care Plan and Kardex in PCC. RN #107 told Inspector #721 that when a resident exhibited a new behaviour or a new intervention was put into place to manage their responsive behaviours, that they would update their Care Plan and verbally communicate this with staff. RN #107 stated that resident #002 had a history of physically aggressive behaviours and had safety interventions in place for a long period of time. When asked how front line staff would know if the safety interventions were to be implemented for a resident, RN #107 stated that registered staff would verbally communicate this at shift report, document in the communication book on the unit and it would be in the residents Kardex.

During an interview with Inspector #721, Assistant Director of Care (ADOC) #105 reviewed resident #002’s clinical record with Inspector #721. ADOC #105 told Inspector #721 that after the incident when resident #002 had exhibited physically aggressive behaviours, they required specific safety interventions. ADOC #105 told Inspector #721 that resident #002’s clinical record included progress notes after the incident indicating that safety interventions were implemented. When asked if all staff were able to access a residents progress notes, they stated that at the time of the incident only registered staff members could view a residents progress notes. ADOC #105 stated that when a resident required safety interventions this should be documented in their Care Plan in PCC. ADOC #105 reviewed resident #002’s Care Plan in PCC and stated that after the incident their Care Plan didn’t indicate safety interventions that were to be in place.

The licensee failed to ensure that when resident #002’s care needs changed and they required safety checks related to an increase in behaviours, that their plan of care was revised to reflect these needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a residents care needs changed their plan of care was reviewed and revised, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the outcome or current status of the individual or individuals who were involved in the alleged, suspected or witnessed incident of abuse of a resident by anyone.

Critical incident System (CIS) report #2887-000024-18 was submitted to the MOHLTC on a specific date. This report documented an alleged incident of staff to resident abuse. This report did not include nor had it been amended to include the outcome or current

status of resident #009 or individuals who were involved in the incident. [s. 104. (1) 3.]

2. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence, with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone.

CIS report #2887-000047-18 was submitted to the MOHLTC on a specific date. This report documented an alleged incident of staff to resident abuse. This report did not include nor had it been amended to include the long-term actions planned to correct the situation and prevent recurrence in relation to this incident involving resident #005. (739)

CIS report #2887-000038-18 was submitted to the MOHLTC on a specific date. This report documented an alleged incident of staff to resident abuse. This report did not include nor had it been amended to include the long-term actions planned to correct the situation and prevent recurrence in relation to this incident involving resident #006. (745)

CIS report #2887-000024-18 was submitted to the MOHLTC on a specific date. This report documented an alleged incident of staff to resident abuse. This report did not include nor had it been amended to include the immediate actions that had been taken to prevent recurrence or the long-term actions planned to correct the situation and prevent recurrence in relation to this incident involving resident #009. (115)

During an interview with the Director of Care (DOC) #103, they had indicated that immediate actions and long term action plans to prevent recurrence and correct the situation were in place, but had not been amended by the home in the on-line critical incident report. (115)

DOC #103 acknowledged that CIS #2887-000047-18, #2887-000038-18, and #2887-000024-18 had not been completed or amended as required by the Act or Regulations. [s. 104. (1) 4.]

Issued on this 30th day of May, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.