Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date May 18, 2022
Inspection Number 2022_1372_0003
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
2063414 Ontario Limited as General Partner of 2063414 Investment LP

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

Lead Inspector
Janet Groux (606)

Additional Inspector(s)
Sarah Kennedy (605)

Inspector Digital Signature
Janet Groux
Digitally signed by Janet Groux
Date: 2022.05.27 12:16:07 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 26-28, 2022

The following intake(s) were inspected:

- Intake # 006584-22 Critical Incident System (CIS) #2887-000007-22 related to a resident's significant change in condition.

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

- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6(4)(a)

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The licensee has failed to ensure registered staff collaborated with one another regarding a resident's change in condition.

Rationale and Summary:

A resident had a significant change in their condition.

The home's policy said the nurse going off shift must report to the nurse coming on shift any resident's changes in health status at the end of the shift.

The resident was identified with a change in their condition during an identified shift. On the following shift, the resident was found unresponsive and resulted in a significant change in their condition. The resident's change in condition was not communicated during the shift to shift report.

Two registered staff said a shift report was completed between the registered staff leaving and the registered staff coming on shift to provide a report about any resident care concerns for follow up on the next shift.

The Director of Care (DOC) acknowledged that the registered staff going off on the identified shift should have communicated to the registered staff coming on that the resident had a change in their condition.

Failure to communicate the resident's change in condition during the shift to shift report may have contributed to the resident's significant change in status.

Sources: a resident's electronic and paper health records, discharge files, the home's shift to shift reports, the home's "shift to shift communication" policy, and interviews with staff.