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

**Hamilton Service Area Office**
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

**Original Public Report**

**Report Issue Date** August 10, 2022
**Inspection Number** 2022_1346_0001
**Inspection Type**
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

**Licensee**
Waterdown Long Term Care Centre, Inc.

**Long-Term Care Home and City**
Alexander Place, Waterdown

**Lead Inspector**
Emmy Hartmann (748)

**Additional Inspector(s)**
Yuliya Fedotova (632)

**Inspector Digital Signature**
EmmyLou Hartmann
Digitally signed by EmmyLou Hartmann
Date: 2022.09.01 11:08:39 -04'00'

## INSPECTION SUMMARY

The inspection occurred on the following date(s): July 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 2022.

The following intake(s) were inspected:

Log #004293-22, related to a fall incident resulting in an injury.
Log #004351-22, related to a fall incident resulting in an injury.
Log #005566-22, related to a fall incident; and unexpected death of a resident.
Log #008002-22, related to a fall incident resulting in an injury.
Log #009574-22, related to a fall incident resulting in an injury.

Log #020092-21, follow-up to CO#001 from inspection #2021_848748_0014 / 009592-21, 013317-21, 015660-21 regarding s.6 (7), compliance due date (CDD) of March 11, 2022.

Log #020093-21, follow-up to CO#002 from inspection #2021_848748_0014 / 009592-21, 013317-21, 015660-21 regarding s.19 (1), CDD of December 22, 2021.

Log #020133-21, follow-up to CO#001 from inspection #2021_848748_0015 / 009742-21, 012741-21, 012821-21, 013980-21, 015005-21 regarding r.50 (2), CDD of January 11, 2022.

**Previously Issued Compliance Order(s)**

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

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| Legislative Reference | | Inspection # | Order # | Inspector (ID) who complied the order |
|---|---|---|---|---|
| LTCHA, 2007 | s.6 (7) | 2022_848748_0014 | 001 | 748 |
| LTCHA, 2007 | s.19 (1) | 2022_848748_0014 | 002 | 748 |
| O. Reg. 79/10 | r.50 (2) | 2022_848748_0015 | 001 | 632 |

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Safe and Secure Home
- Skin and Wound Prevention and Management

## INSPECTION RESULTS

**During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.**

### NON-COMPLIANCE REMEDIED

***Non-compliance*** was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

**NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)**

**The licensee has failed to ensure that the home had an infection prevention and control lead whose primary responsibility was the home's infection prevention and control program.**

During an inspection, the DOC identified that there was no Infection Prevention and Control (IPAC) Lead in the home for a period between June 17 and July 7, 2022, and they were combining the role of the DOC and the IPAC Lead.

Documentation review identified two COVID-19 Self Assessment Audit Tool for Long-Term Care Homes and Retirement Homes were not completed by the home between June 11 and July 7, 2022.

On July 7, 2022, the Regional Clinical Manager confirmed that the interim IPAC lead would start their role on July 8, 2022, in the home.

There was minimal risk of impact on the IPAC prevention and management system in the home when the licensee did not have a designated IPAC lead for a period between June 17 and July 7, 2022.

**Sources:** COVID-19 Self Assessment Audit Tool for Long-Term Care Homes and Retirement Homes; observations, interviews with the DOC and the Regional Clinical Manager.

Date Remedy Implemented: July 8, 2022

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## WRITTEN NOTIFICATION: REQUIRED PROGRAMS

**NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 79/10 *r.48(1)4***

**The licensee has failed to ensure that their pain management program to identify and manage pain in residents was implemented when a resident complained of pain.**

The home's pain policy identified that a resident would have a comprehensive pain assessment under assessments in Point Click Care (PCC) completed with any new pain.

On an identified date, the resident complained of pain which was new pain for the resident. The doctor was notified, new orders were prescribed to manage the pain; however, there was no pain assessment completed in PCC.

The DOC identified that there should have been a comprehensive pain assessment completed on the resident's new pain.

There was a risk that the resident's pain may not have been managed as required when there was no comprehensive pain assessment conducted on the pain.

**Sources:** A resident's progress notes, MAR, care plan, assessments; the home's Pain Management Program policy, last revised March 6, 2022; interview with DOC.

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## WRITTEN NOTIFICATION: INTEGRATION OF ASSESSMENTS

**NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: FLTCA, 2021 *s.6(4)a***

**The licensee has failed to ensure that the nursing staff and the doctor collaborated with each other in the assessment of a resident's injury following a fall.**

The resident had a fall on an identified date, and they were assessed and noted as sustaining injuries on a specified area. A day later, another injury on a different area was reported to RPN #118. RPN #118 completed a skin and wound evaluation and wrote the issue in the doctor's book. There was no change in the resident's plan of care.

The doctor came in the following day, and in their notes, they acknowledged the initial injury to the resident post- fall but not the second injury. A few days later, the resident's condition changed and they were sent to the hospital. The resident's condition continued to decline and they subsequently passed away.

The doctor said they were not aware of the injury that was identified a day after they had fallen. If they had been aware, they may have ordered a diagnostic test and the resident's plan of care with assistance in personal care may have changed.

The resident may not have received the care they required as the assessments of the nursing staff and the doctor were not integrated and consistent with each other.

**Sources:** A resident's progress notes, care plan, assessments; the home's investigation package; interviews with an RPN, and the doctor.

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## WRITTEN NOTIFICATION: BINDING ON LICENSEES

**NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: FLTCA, 2021 *[s. 184 (3)]***

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applied to the long-term care home, the Minister's Directive was complied with. In accordance with the Minister's Directive: COVID-19 response measures for long-term care home (effective April 27, 2022), the Licensee was required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, were followed.

A) During the inspection on July 8, 2022, it was observed that an incoming visitor was not asked screening questions by the home's staff.

The Regional Clinical Manager indicated that any visitor would be asked screening questions.

According to the Minister's Directive homes must ensure that all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter home.

The residents may have been placed at increased risk when a visitor was not screened for COVID-19 symptoms at the point of entry.

**Sources:** the Minister Directive: COVID response measures for long-term care homes, under the Fixing Long-Term Care Act, 2021 (effective April 27, 2022); observations; interview with Regional Clinical Manager, and other staff.

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B) Review of COVID-19 Self Assessment Audit Tool for Long-Term Care Homes and Retirement Homes identified there was no COVID-19 self-assessments completed in the home, which was not in outbreak, between June 11 and July 10, 2022, which was confirmed by the DOC.

There was a minimal risk when the COVID-19 Self-Assessment Tool was not reviewed by the home at a minimum every two weeks.

**Sources:** COVID-19 Self Assessment Audit Tool for Long-Term Care Homes and Retirement Homes; interview with the DOC.

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## WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

**NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 *[s. 34 (2)]***

**The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.**

A) A resident's skin alteration did not have the details of the weekly skin assessment documented for an identified time frame, which was confirmed by staff #107.

Documentation in the resident's Electronic Medication Administration Record (eMAR) was checked off identifying that a weekly skin alteration assessment for the resident was conducted with no details of the assessment documented.

The resident had a potential risk of their wound to deteriorate as no details of their skin assessment had been documented, which was used as a reference for staff to provide treatment or make changes to the treatment.

**Sources:** A resident's Skin and Wound Assessment, eMAR; interview with staff #107 and other staff.

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B) A resident's skin alteration did not have the details of their weekly skin assessment documented for an identified time frame, which was confirmed by the staff #107.

Documentation in the resident's eMAR was checked off on four instances, under the directions to take ipod pictures of the resident's skin alteration once a week and to complete weekly skin alteration assessments. There was no documented details of the assessment.

The resident had a potential risk of their wound to deteriorate as no details of their skin assessment had been documented, which was used as a reference for staff to provide treatment or make changes to the treatment.

**Sources:** A resident's Skin and Wound Assessment, eMAR; interview with staff #107 and other staff.

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## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

**NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 *[s. 102 (2) B]***

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 (b) indicated that at minimum Routine Practices shall include: b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment

contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

During the inspection on July 8, 2022, it was observed that RPN #104 during administration of medication to three residents did not complete Hand Hygiene after resident environment contact.

The home's Hand Hygiene Program identified that all staff would comply with the hand hygiene program including the 4 Moments of Hand Hygiene.

The DOC confirmed that staff follow Public Health Guidelines and the home's policy on Hand Hygiene.

The residents may have been at increased risk of transmitted infection when hand hygiene was not completed by the staff between contacts with the residents' environments.

**Sources:** LTC Hand Hygiene Program Version #5 (Revised Date: 11/08/2021); observations; interview with RPN #104 and the DOC.

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## 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. Please include the inspection report # and the order or AMP #;
(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

email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.