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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: November 16, 2023	
Inspection Number: 2023-1346-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Waterdown Long Term Care Centre Inc.	
Long Term Care Home and City: Alexander Place, Waterdown	
Lead Inspector Emma Volpatti (740883)	**Inspector Digital Signature** Emma Volpatti Digitally signed by Emma Volpatti Date: 2023.11.21 13:03:51 -05'00'
Additional Inspector(s) Jennifer Allen (706480)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 18-20, 23-26, 2023

The following intake(s) were inspected:

- Intake: #00093580 (Critical Incident (CI) #2861-000026-23 related to falls prevention and management.
- Intake: #00094388 Complaint regarding care and services, skin and wound, palliative care and pain management.

The following intake was completed in this inspection: Intake #00093580, CI# 286100002623 was related to falls prevention and management.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Palliative Care

Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A situational care conference was held with members of the care team and a resident's Substitute Decision Makers (SDM)**'**s. During the conference, the resident's transfer status was discussed.

Review of the resident's plan of care indicated that there were two different assistance levels located under transfers.

A Co-Director of Care (CDOC) indicated that on the day of the conference, they entered the resident's room with their SDM and noted there were two transfer logos above the bed, both indicating different transfer statuses. They acknowledged that this did not provide clear direction for the staff on how the resident is to be transferred.

Failing to provide clear direction to the staff posed a risk of a potential improper transfer occurring.

Sources: Interview with a CDOC, a resident's clinical record. **[740883]**

WRITTEN NOTIFICATION: When Reassessment, Revision is Required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

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

Rationale and Summary
A situational care conference was held with a resident's SDM's and other members of the care team. The SDM's identified some concerns with a skin alteration. A CDOC informed them that staff would

apply a specific intervention to the area of altered skin integrity.

A review of the resident's clinical record indicated there was no orders created for this treatment, and no further documentation of this treatment being done.

A CDOC acknowledged that an order should have been created to direct staff to apply this treatment and it was not.

Failing to revise a resident's plan of care when their care needs changed, posed a risk of skin deterioration.

Sources: A resident's clinical record, interview with a CDOC. **[740883]**

WRITTEN NOTIFICATION: Plan of care - Integration of Assessments

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Rationale and Summary
A resident's Minimum Data Set (MDS) and Resident Assessment Protocols (RAP) annual assessment was completed and locked, and the resident's corresponding care plan was completed and locked 6 days later.

The resident's care plan which was intended to be updated from the MDS and RAP coded data, were not consistent and complementary of each other. For seven activities of daily living (ADL's), the MDS and RAP coding data did not match the resident's care plan in regards to assistance level.

The Resident Assessment Instrument (RAI) coordinator acknowledged that the MDS and RAP information that are coded are used to create and update the care plan and should be reflective and complimentary of each other.

Failure to have the different aspects of the resident's care consistent and complimentary with each other increased the risk of unclear directions to maintain the resident's comfort and safety.

Sources: A resident's health records, interview with a Personal Support Worker (PSW) and other staff. **[706480]**

WRITTEN NOTIFICATION: Duty of Licensee to Comply with Plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

A) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided as specified in the plan.

Rationale and Summary
A resident's Physician (MD) ordered a specific treatment and the order was not entered into the resident's eMAR when it was received. 13 days later, a Registered Nurse (RN) sent a message to the MD requesting clarification on the order. The MD provided clarification the same day and the order was added to the eMAR.

A CDOC acknowledged that for a period of 13 days, staff were not applying the treatment as ordered by the MD.

Failing to ensure that the care set out in a resident's plan of care was provided to them put the resident at an increased risk of further skin deterioration.

Sources: Interview with a CDOC, a resident's clinical record. **[740883]**

B) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided as specified in the plan.

Rationale and Summary
A resident had an order to chart on the resident's condition every four hours. Review of the resident's clinical record indicated the resident's condition under the order was charted on ten times, out of a possible 51 times.

The Director of Care (DOC) acknowledged that the order was not followed as specified in the plan of care.

Failing to ensure that the care set out in the plan of care for a resident was provided as specified in the plan, posed a risk of a deterioration in condition going unnoticed.

Sources: Interview with the DOC, a resident's clinical record. **[740883]**

C) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided as specified in the plan.

Rationale and Summary
The MD wrote an order for staff to complete a specified treatment for a resident at the present time and then again in five days. A review of the resident's clinical record indicated the initial specified treatment was never completed.

A CDOC acknowledged that the order was not completed as prescribed and it should have been.

Failing to ensure that the care set out in the plan of care was provided to a resident, posed a risk of further deterioration going undetected.

Sources: Interview with a CDOC, a resident's clinical record. **[740883]**

WRITTEN NOTIFICATION: Duty to Protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from neglect.

Rationale and Summary
Section 7 of Ontario Regulation 246/22 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident participated in regular recreation sessions with a therapist who was contracted by the home. Review of their clinical record indicated that there were three occasions over a three-month period that the resident complained of pain in a specified area during the sessions.

The therapist documented they would encourage the resident to use a different area of their body during the sessions instead. There was no indication that any other staff were informed of these complaints of pain, specifically PSW's, registered staff members or the management team.

Furthermore, there was no indication that any interventions were done to address the pain the resident was experiencing during the sessions, or assessment by a health care provider. At the time of the sessions, the resident had an order for as needed medication for pain. Review of their eMAR indicated that the as needed pain medication was never administered to the resident before or after the sessions.

The DOC and Administrator both acknowledged that the therapist should have informed someone of the complaints of pain from the resident that they were experiencing during the sessions, so that it could have been addressed.

Failing to protect the resident from neglect posed a risk of harm to the resident.

Sources: Interview with DOC and other staff, a resident's clinical record, the home's policy. **[740883]**

WRITTEN NOTIFICATION: General Requirements

NC #006 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 the skin and wound program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
A CDOC sent a secure message to the MD stating that a resident's limb was red and warm to touch, and requested the MD to consider a certain intervention.

The MD indicated that they were in the home during that day for a care conference with the resident's SDM's and assessed the resident's limb. They acknowledged that they did not document their assessment and they should have.

Sources: Interview with a CDOC and other staff, a resident's clinical record. **[740883]**

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

A) The licensee has failed to ensure that a resident received immediate treatment and interventions for a wound.

Rationale and Summary
A resident had an initial skin assessment completed for an identified wound. A review of their clinical record indicated that a wound treatment was not initiated until six days later.

A CDOC acknowledged that the treatment was not immediately initiated when the wound was first identified, and it should have been.

Failing to initiate immediate treatment for a resident's wound posed a risk of potential wound deterioration.

Sources: Interview with a CDOC, a resident's clinical record, the home's policy. **[740883]**

B) The licensee has failed to ensure that a resident received immediate treatment and interventions for a skin alteration.

Rationale and Summary
A resident had an initial skin assessment completed for a new skin alteration. A review of their clinical record indicated that a treatment was never initiated for the wound.

A CDOC acknowledged that no treatment was ever initiated for the skin alteration, and it should have been.

Failing to initiate immediate treatment for a resident's skin alteration posed a risk of potential wound deterioration.

Sources: Interview with a CDOC, a resident's clinical record, the home's policy. **[740883]**

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly by a member of the Registered Nursing staff, if clinically indicated.

Rationale and Summary
A resident had numerous areas of altered skin integrity, as exhibited by skin and wound assessments in their clinical record. A review of five of the most current skin alterations showed gaps between weekly assessments.

A CDOC acknowledged that there were gaps in the assessments of the resident's altered skin integrity, and all of the alterations should have been assessed at least weekly.

Failing to ensure that the resident's areas of altered skin integrity were assessed weekly posed a risk of wound deterioration going unnoticed.

Sources: A resident's clinical record, the home's policy, interview with a CDOC. **[740883]**

WRITTEN NOTIFICATION: Pain Management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

The licensee has failed to ensure that the home's pain management program provided for strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had a pain management program which provided for strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the home's policy.

Rationale and Summary

iv) A Registered Practical Nurse (RPN) sent a secure message to the MD in the morning stating that a resident was complaining of pain in a specified area. Later that same day, RN #110 documented that the resident was complaining of stiffness in that same area and was unable to extend one of their limbs. Review of the resident's clinical record indicated that there was an order for as needed medication for pain, and it was not administered on that day. No other interventions for pain management were documented during that day.
v) An RPN sent a secure message to the MD in the evening stating that a resident was complaining of pain. Review of a resident's clinical record indicated that there were two orders for as needed pain medication. None of these medications were documented as administered on that day. No other interventions for pain management were documented. The Director of Care (DOC) acknowledged that an as needed pain medication should have been administered.
vi) A resident was receiving end-of-life care. An RPN documented in the evening that the resident had labored breathing with increased respirations. The RPN contacted the MD who increased the resident's routine pain medication. In addition, there was an order present for an as needed pain medication for breakthrough. During the night, an RN documented that the resident's respirations were elevated. In the morning, an RPN documented that they called the residents SDM to update them on the resident's labored breathing. There was no as needed pain medication administered to the resident from the evening up until the resident passed away the following day in the afternoon. The MD acknowledged that breakthrough means pain exhibited in between scheduled medication doses, and the resident should have received as needed pain medication when they were demonstrating labored breathing with increased respirations.

Failing to provide prompt pain management interventions to a resident posed a risk of the resident's pain being unmanaged.

Sources: Interview with the DOC and other staff, a resident's clinical record, the home's policy. **[740883]**

COMPLIANCE ORDER CO #001 Medication Management System

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Provide education for all Registered Nursing staff who work regularly on home area three on:
- The importance of transcribing physician's orders immediately when they are received; and
- Policy number (#) 8.1 in the home's pharmacy manual; and
- The College of Nurses medication practice standard; and
2. Document the education, including the date it was held, the staff members who attended and the staff's signatures that they understood the education; and
3. Complete random controlled substance audits twice per week for one month to ensure that:
- Controlled substances are administered to residents in accordance with the home's policy #8.1; and
- No controlled substance is administered to a resident without a physician's order in the eMAR; and
- Include in the audits any discrepancies identified and any corrective actions taken; and
4. The home must keep a record of the education and audits for the LTCH Inspector to review.

Grounds
The licensee has failed to ensure that the written policies and protocols developed for the medication management system were implemented in the home.

Rationale and Summary
On an identified date in the morning, a resident's MD gave a verbal order to discontinue all previous controlled substance medication orders and created a new order in replacement. There was no change in the order, however, as the new order was the same as the previous order.

The resident's medication orders in their clinical record indicated that the pharmacy discontinued the previous order, but an RN did not input the new order into the eMAR until three days later. A review of the controlled substance administration record sheets indicated that on two days, the controlled substance was signed as administered to resident.

The home's pharmacy policy manual indicated that a medication that is to be administered must be verified for accuracy against the eMAR. It further indicated that immediately after the medication is administered, it must be documented on the eMAR before moving on.

The DOC acknowledged that the staff did not implement the home's medication policy when the resident was administered a controlled substance for two days without an order in their eMAR.

Failing to implement the home's medication policy posed a significant risk to the resident.

Sources: The home's policy, interview with the DOC and other staff, a resident's clinical record. **[740883]**

This order must be complied with by: December 21, 2023

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.