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: July 8, 2024	
Inspection Number: 2024-1346-0001	
Inspection Type: Critical Incident Follow up	
Licensee: Waterdown Long Term Care Centre Inc.	
Long Term Care Home and City: Alexander Place, Waterdown	
Lead Inspector Leah Curle (585)	**Inspector Digital Signature**
Additional Inspector(s) Kerry O'Connor (000769) Sydney Withers (740735)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15-17, 21-24, 27-31, 2024 and June 3, 2024.

The following Critical Incident (CI) intakes were inspected:

- #00107084/2861-000004-24, #00109421/2861-000013-24 and #00114102/2861-000031-24 related to resident care and support services
- #00112891/2861-000027-24 related to infection prevention and control
- #00114512/2861-000032-24 related to prevention of abuse and neglect

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The following Compliance Order (CO) follow-up intakes from inspection #2023-1346-005 were inspected:

- #00110550 related to Ontario Regulation (O. Reg.) 246/22 s. 161 (2) - requirements on licensee before discharging resident. Compliance Due Date (CDD): April 1, 2024.
- #00110546 related to O. Reg. 246/22 s. 74 (2) (a) - Nutritional Care and Hydration Programs. CDD: April 8, 2024.
- #00110547 related to Fixing Long-Term Care Act (FLTCA), 2021 s. 184 (3) - Directives by Minister. CDD: April 29, 2024.
- #00110549 related to O. Reg. 246/22 s. 102 (2) (b) - Infection Prevention and Control Program. CDD: April 29, 2024.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2023-1346-0005 related to O. Reg. 246/22, s. 74 (2) (a) inspected by Sydney Withers (740735)

Order #003 from Inspection #2023-1346-0005 related to FLTCA, 2021, s. 184 (3) inspected by Leah Curle (585)

Order #004 from Inspection #2023-1346-0005 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Leah Curle (585)

Order # from Inspection #2023-1346-0005 related to O. Reg. 246/22, s. 161 (2) inspected by Kerry O'Connor (000769)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Admission, Absences and Discharge

INSPECTION RESULTS

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)
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to uphold a resident's right to be afforded privacy regarding their personal needs.

Rationale and Summary

During the inspection, a resident's personal health information and documentation regarding their care needs were observed in a common area. Co-Director of Care

(DOC) #102 acknowledged the information was not upheld in a way that afforded the resident's right to have their health information and personal needs kept private.

Prior to the end of the inspection, the information was moved out of the common area.

Sources: observation of written documentation of a resident's personal health information and care needs in a common area, interviews with Co-DOC #102 and others. [740735]

Date Remedy Implemented: June 3, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure a resident's plan of care was reviewed and revised when the care set out in the plan was no longer necessary related to requirements for infection prevention and control (IPAC).

Rationale and Summary
A resident's written plan of care directed staff to use personal protective equipment (PPE) and noted specific additional precautions which were necessary for the purposes of IPAC.

A personal support worker (PSW) stated additional precautions were not required when providing care to the resident. The IPAC Lead/Co-DOC #104 confirmed the resident no longer required additional precautions and acknowledged the written plan of care had not been revised.

Prior to the end of the inspection, the plan of care was updated and requirements for additional precautions were removed from the written plan of care.

Sources: a resident's written plan of care, interviews with a PSW and the IPAC Lead/Co-DOC #104 [585].

Date Remedy Implemented: May 28, 2024

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that an intervention for falls prevention and management was included in a resident's written plan of care.

Rationale and Summary
A resident's Minimum Data Set (MDS) assessments and Resident Assessment Protocols (RAPS) noted they were a falls risk, and they required a specified fall intervention. The resident's written plan of care was reviewed and did not include the specified intervention.

The DOC acknowledged the intervention was not included in the resident's written plan of care as required.

Failure to ensure the written plan of care included the fall intervention increased risk to the resident for potential falls or injury.

Sources: A resident's MDS assessments and RAPS (November 2023 and March 2024), a resident's written plan of care, interview with the DOC. [000769]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A) The licensee has failed to ensure the care set out in a resident's plan of care was documented on a date in April 2024.

Rationale and Summary
A review of a resident's clinical record identified a gap in PSW documentation in Point of Care (POC) for 11 tasks that were to be completed on a specified shift in April 2024.

The DOC confirmed PSWs were to document care provided to residents on each shift in POC.

Sources: a resident's clinical record, interview with the DOC and others. [740735]

B) The licensee has failed to ensure that staff documented the care provided to a resident appropriately, as set out in the plan of care.

Rationale and Summary
A resident's plan of care noted they required a specific level of assistance from staff with a specified device for transfers.

In December 2023, multiple PSW staff documented in POC that the resident received a different level of assistance with transfers than what was required in their plan of care.

A PSWs reported they transferred the resident according to their plan of care but charted incorrectly.

Failure to ensure that documentation of care provided to the resident was accurate had potential to contribute to inaccurate assessments of their care needs.

Sources: a resident's plan of care, a resident's POC documentation in December 2023, interviews with a PSW and other staff. [000769]

WRITTEN NOTIFICATION: Dietary Services and Hydration

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 15 (2)
Dietary services and hydration
s. 15 (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

The licensee has failed to ensure that a resident was provided fluids that were safe.

Rationale and Summary
A resident had an identified diagnosis with a history of a known specified concern. Their diet order noted they required thickened fluids to a specified consistency.

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During the inspection, a staff member prepared and served a fluid to the resident at a consistency that was not in accordance with their plan of care. The staff did not follow the mixing guidelines for thickening fluids or the home's policy for thickened fluids.

The Registered Dietitian (RD) acknowledged that the fluid consistency served to the resident would have been unsafe.

Failure to ensure the resident received fluids thickened to a safe consistency based on their assessed needs increased their risk of potentially negative outcomes.

Sources: observation of a nourishment pass, a resident's clinical record, Nestle ThickenUp Mixing Chart, policy "Thickened Fluids" (reviewed February 14, 2022), interviews with the RD and other staff. [740735]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the long-term care home (LTCH)'s written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
Section two of the Ontario Regulation (O. Reg.) 246/22 defines different forms of abuse, as did the LTCH's written policy on abuse.

A) On a specified date in 2024, an allegation of staff to resident abuse was reported to a registered nursing staff. The home's written abuse policy required staff to report their suspicion of abuse immediately to the senior administrative personnel. Co-DOC #102 confirmed that an on-call manager was not immediately notified of the allegation and the home did not start their investigation into the incident immediately.

B) It was identified that a registered nursing staff failed to immediately complete a head-to-toe skin assessment or pain assessment for a resident after they were made aware of the allegation of abuse of the resident, as required by the home's written abuse policy. The DOC acknowledged the registered nursing staff should have completed the required assessments immediately after they became aware of the allegation of abuse.

Failure for the staff to comply with the home's written abuse policy led to the required nursing assessments not being completed, LTCH management not being informed immediately of an alleged incident of abuse and delayed investigation into the incident.

Sources: a resident's clinical record, policy "LTC Abuse - Zero-Tolerance for Resident Abuse and Neglect" (reviewed July 2023), interviews with the DOC, Co-DOC #102 and a registered nursing staff member. [740735]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff

that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by staff that resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director. Pursuant to subsection (s) 154 (3), the licensee was vicariously liable for staff members failing to comply with s. 28 (1).

Rationale and Summary
An alleged incident of staff to resident abuse was reported to a member of the registered nursing staff on a specified date in 2024. The incident was reported not reported to the Director immediately, as confirmed by Co-DOC #102.

Sources: a resident's clinical record, a CIS report, interviews Co-DOC #102 and other staff. [740735]

WRITTEN NOTIFICATION: Menu Planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that all planned menu items were available and offered to a resident.

Rationale and Summary
A resident was identified as being a specified nutrition risk and was being monitored for a specified concern. A master diet list (MDL) in the home included planned menu items for the resident.

During a snack observation, a planned menu item was not available on the nourishment cart or offered to the resident. A PSW confirmed the item was not available. The Culinary Manager (CM) acknowledged that the planned menu item listed on the MDL should have been available and offered to the resident.

Failure for all planned menu items to be available and offered had potential for negative impact to the resident.

Sources: a snack service observation, a resident's clinical record, MDL, interviews with the CM, a PSW and other staff. [740735]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that when a resident demonstrated symptoms of infection, the symptoms were recorded on every shift.

Rationale and Summary
The licensee was to ensure that on every shift, symptoms indicating the presence of infection were monitored in accordance with any standard or protocol issued by the Director and the symptoms were recorded.

On a date in April 2024, during an identified shift, a resident demonstrated symptoms of infection. The resident was placed in isolation. On the following shift,

there was no documentation on their condition; however, the following day, staff documented the resident had exhibited the symptoms of infection.

The IPAC Lead/Co-DOC #104 confirmed staff did not follow the home's expectation on documenting symptoms of infection each shift while the resident was on additional precautions and isolation as a result of demonstrating symptoms of infection.

Failure to record on every shift symptoms indicating the presence of infection had potential to lead to an increase in transmission of the infection in the home.

Sources: Long Term Care (LTC) Daily Infection Monitoring -Jarlette Health Services (JHS) progress notes for a resident, interview with IPAC Lead/Co-DOC #104. [585]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when a verbal complaint was made to a staff member concerning the care a resident alleging harm or risk of harm to the resident, an investigation commenced immediately.

Rationale and Summary
On a specified date in 2024, a complaint was made to a registered nursing staff alleging abuse of a resident.

The home's complaints procedure required staff to document the concern and actions taken on a Concern and Complaint Form, initiate an investigation and inform their supervisor of the concern. Once made aware, the on-call manager was to begin an investigation if not already started.

It was identified through record review and interviews that the Concern and Complaint Form, and associated investigation were not initiated immediately for the allegation.

Failure of registered nursing staff to follow the home's complaints process and commence an investigation immediately resulted in a delayed response to the resident's concerns.

Sources: a resident's clinical record, policy "LTC Concerns and Complaints Management" (reviewed March 2024), Concern and Complaints Form, interviews with the DOC and a registered nursing staff. [740735]