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: August 28, 2024	
Inspection Number: 2024-1346-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Waterdown Long Term Care Centre Inc.	
Long Term Care Home and City: Alexander Place, Waterdown	
Lead Inspector Sydney Withers (740735)	**Inspector Digital Signature**
Additional Inspector(s) Brittany Wood (000763)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 11-12, 15-19, 22-26, 29-30, 2024.

The following intakes were inspected:

- Intake 00116773 was related to falls prevention and management;
- Intake 00119589 was related to abuse; and
- Intake 00117186 was related to concerns regarding medication management and the complaint process.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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) (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 failed to ensure that the written plan of care for a resident set out the planned care related to a demonstrated responsive behaviour and a specified fall intervention.

Rationale and Summary
A) A resident fell and demonstrated a responsive behaviour toward the staff providing their care at the time of their fall. The home's responsive behaviour

program required staff to update a resident's plan of care to reflect identified risk factors and the appropriate interventions. Nursing management acknowledged that the resident's plan of care did not set out planned care related to the demonstrated behaviour.

Failure for the resident's plan of care to set out planned care related to a behaviour may have resulted in triggers and interventions not being communicated to staff.

Sources: Resident's clinical record, critical incident system (CIS), responsive behaviours program, interviews with staff.

B) A resident was to have a specified fall intervention in place at all times due to their risk of falling. Staff indicated that at the time of the resident's fall, they were not fully informed of the specified fall intervention or expectations around how to implement it. Nursing management was unable to demonstrate what planned care was set out related to the specified fall intervention at the time of the resident's fall.

Failure for the resident's plan of care to set out planned care related to the specified fall intervention may have contributed to care not being provided to the resident as required.

Sources: Resident's clinical record, CIS, long-term care home (LTCH) investigation records, interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

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

Rationale and Summary
A resident fell and required an intervention to support healing of their injury. The plan of care provided two opposing directions regarding the application of the intervention. Staff acknowledged that the plan of care did not set out clear direction to staff on when to apply the intervention.

Failure for the plan of care to set out clear direction to staff may have led to staff uncertainty about when the intervention was to be applied.

Sources: Resident's clinical record, CIS, interview with staff.

WRITTEN NOTIFICATION: Duty of the Licensee to Comply With Plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
The physician wrote an order for a resident to receive a specified intervention. The order was not sent to the pharmacy as required by the home's order processing policy. Staff acknowledged that an intervention was recommended by the physician due to an identified risk to the resident and had not been processed; therefore, was not provided to the resident as specified in their plan of care.

Failure to ensure care set out in the plan of care was provided may have contributed to continued risk to the resident.

Sources: Resident's clinical record, order processing policy, interview with staff.

WRITTEN NOTIFICATION: Documentation

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.

The licensee failed to ensure that provision of care set out in a resident's plan of care was documented.

Rationale and Summary
A resident required a specified intervention for comfort. Staff were expected to document multiple care activities throughout the day while the intervention was in use. The plan of care did not provide a task for staff to document this care; therefore, the care was not documented.

Failure for staff to document care when the intervention was in use may have impacted staff accountability to ensure the required care was provided.

Sources: Resident observation, resident's clinical record, LTCH policy, interview with staff.

WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee failed to document the outcomes of the care set out in a resident's plan of care.

Rationale and Summary
Staff approached a resident to provide care on a specified shift and the resident refused care. There was no documentation in the resident's plan of care to support that they refused care.

Sources: Resident's clinical record, interviews with staff.

WRITTEN NOTIFICATION: Complaints Procedure - Licensee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure they immediately forwarded a written complaint they received concerning the care of a resident to the Director as required by the regulations.

Ontario Regulation 246/22 subsection 109 (1) described a complaint that a licensee was required to immediately forward to the Director under clause 26 (1) (c) of the Act as a complaint that alleged harm or risk of harm to one or more residents.

Rationale and Summary
A written complaint alleging harm to a resident was emailed to nursing management and was not forwarded to the Director.

Sources: Written complaint, LTCH concern and complaint form, LTCHomes.net portal, interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary

assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee failed to ensure a resident's plan of care was based on, at a minimum, an interdisciplinary assessment of their mood and behaviour patterns, any identified responsive behaviours, potential behavioural triggers and variations in their functioning at different times of the day.

Rationale and Summary
A resident exhibited responsive behaviours at the time of their admission to the LTCH. The home's responsive behaviours program required staff to screen and assess all residents for risk of responsive behaviours on admission using a specified assessment form. Nursing management acknowledged the specified assessment had never been completed for the resident to establish their behaviours, triggers and suitable interventions.

Failure to ensure the resident's plan of care was based on an interdisciplinary assessment related to responsive behaviours may have led to behaviours and triggers not being identified, interventions not trialed and communication gaps related to the resident's behaviours.

Sources: Resident's clinical record, responsive behaviours program, interviews with staff.

WRITTEN NOTIFICATION: Required Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure their fall prevention and management program was implemented. Specifically, the home's falls program, where it was to provide for strategies to reduce or mitigate falls, was not implemented for a resident.

Rationale and Summary
A resident was to have a specified fall intervention in place at all times due to their risk of falling. The resident fell and staff identified that the required intervention was not in place at the time of the fall.

Failure to ensure the fall prevention intervention was in place at the time of the resident's fall posed a risk of injury.

Sources: Resident's clinical record, fall prevention and management program, interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure

injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that a resident received immediate treatment to promote healing and prevent infection when they exhibited altered skin integrity.

Rationale and Summary
A resident fell, sustaining an area of altered skin integrity. A treatment order was entered into their plan of care multiple weeks after they acquired the skin issue. Staff confirmed the treatment order should have been entered into the resident's plan when staff initially identified the altered skin integrity.

Failure to ensure the resident received immediate treatment increased the risk of infection and delayed healing.

Sources: Resident's clinical record, CIS, skin and wound care program, interview with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure a resident was reassessed at least weekly when they exhibited altered skin integrity.

Rationale and Summary
A resident fell, sustaining multiple areas of altered skin integrity. The home's skin and wound program required staff to complete weekly skin reassessments. A weekly reassessment was missed on a specified week.

Failure to ensure the resident's altered skin integrity was reassessed at least weekly increased the risk of changes in their skin integrity not being identified.

Sources: Resident's clinical record, CIS, skin and wound care program, interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee failed to ensure resident monitoring protocols were developed to meet the needs of residents with responsive behaviours.

Rationale and Summary
The home could not demonstrate resident monitoring protocols developed to meet

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the needs of residents with responsive behaviours.

When responsive behaviour monitoring protocols were not developed, there was no formal direction for staff to direct them when to initiate monitoring strategies, what monitoring tools were available for use or the expectation for analyzing and making plan of care revisions based on the results of behaviour monitoring.

Sources: Responsive behaviours program, interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 4.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
4. Protocols for the referral of residents to specialized resources where required.

The licensee failed to ensure protocols for the referral of residents to specialized resources were developed to meet the needs of residents with responsive behaviours.

Rationale and Summary
The home could not demonstrate protocols for the referral of residents to specialized resources to meet the needs of residents with responsive behaviours who required specialized support.

When protocols for managing specialized resources referrals were not developed, there was no formal direction for staff to direct them when to consider referrals to

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specialized resources, which resources were available on a referral basis, who was responsible for initiating and processing the referral, or the referral process. This posed a risk of residents not receiving specialized support to manage their responsive behaviours where indicated.

Sources: Responsive behaviours program, interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure actions were taken to respond to the needs of a resident, including:
A) Assessments and interventions related to their responsive behaviours; and
B) Use of a specified tool to observe and analyze the resident's behaviours.

Rationale and Summary
A) Staff obtained consent to process a referral to a specialized resource for an assessment of a resident's responsive behaviours. The referral process was not completed and the resource was not notified of the resident's care need when it was initially identified.

Failure to fully complete the referral process resulted in a delayed assessment of the resident's responsive behaviours by a specialized resource.

Sources: Resident's clinical record, interview with staff.

B) Staff were to document the behaviours demonstrated by a resident on each shift. There was no analysis completed of the data collected to detect patterns in the resident's behaviours.

Failure to analyze behaviours demonstrated by the resident posed a risk of behavioural trends and triggers not being identified, and planned care not being developed in response.

Sources: Resident's clinical record, data collection tool, interview with staff.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.
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:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or

B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee failed to ensure that when they received a written complaint concerning the care of a resident, their response included the following requirements under paragraph three (3) of subsection 108 (1):
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Rationale and Summary
A written complaint was emailed to the LTCH alleging harm to a resident. Nursing management acknowledged that their response to the complainant did not include the requirements under paragraph 3.

Failure to ensure the response to the complainant included the required information led to communication breakdown between the LTCH and complainant, and potential for delayed access to the Ministry of Long-Term Care complaint submission process.

Sources: Written complaint, LTCH concern and complaint form, interviews with staff

and the complainant.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee failed to ensure a documented record was kept in the home that included every date on which any response was provided to the complainant.

Rationale and Summary
A written complaint concerning the care of a resident was emailed to the LTCH. Nursing management followed up with the complainant about their concerns and provided an update; however, did not document the date on which their response was communicated.

Sources: Written complaint, LTCH concern and complaint form, interview with staff.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home

that includes,
(f) any response made in turn by the complainant.

The licensee failed to ensure a documented record was kept in the home that included any response made in turn by the complainant, when provided information by the licensee.

Rationale and Summary
A written complaint concerning the care of a resident was emailed to the LTCH.

i) Nursing management followed up with the complainant about their concerns and provided an update; however, did not document the response made in turn by the complainant.

ii) Nursing management provided a final response to the complainant regarding their concerns; however, did not document the response made in turn by the complainant. They acknowledged that the complainant was not satisfied with the outcome of the home's investigation.

Sources: Written complaint, LTCH concern and complaint form, interview with staff.

WRITTEN NOTIFICATION: Medication Management System

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that a written policy within their medication management system was implemented.

Rationale and Summary
An order was written for a medication change and included one resident identifier on the prescriber's order form. The home's orders policy directed staff to ensure orders were processed with multiple identifiers documented on the prescriber's order form. A pharmacist consultant acknowledged that only one identifier was present on the form and that multiple identifiers were required.

Failure for multiple identifiers to be documented on the order form may have increased the risk of a medication error.

Sources: Prescriber's order form, orders policy, interview with pharmacist consultant.

WRITTEN NOTIFICATION: Residents' Drug Regimes

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee failed to ensure when a resident was taking a specified drug, there was monitoring and documentation of their response and the effectiveness of the drug.

Rationale and Summary
An order was written to change a resident's medication. The home's medication administration policy directed staff to complete a specified assessment when there was a change in the prescribed medication. Staff acknowledged the required assessment was not completed for the resident when changes to their medication were implemented.

Failure to complete and document the required monitoring of the resident following a change in their medication posed a risk of changes to their clinical status not being detected.

Sources: Resident's clinical record, medication administration policy, interview with staff.

WRITTEN NOTIFICATION: Resident Records

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure a resident's written record was kept up to date at all times.

Rationale and Summary
i) A consulting physician assessed a resident and wrote an order for a change in their medication dosage. There was a significant delay in the entry of their assessment

note into the resident's written record. When concerns arose regarding the change to the resident's medication, the home's physician was unable to locate an assessment.

ii) Concerns were brought forward to the home's physician regarding a change to the resident's medication and specified outcomes to the resident. The physician acknowledged the resident's observed change in status and made an adjustment to their medication. Documentation pertaining to the concerns, changes to the resident's status and actions taken as a result were not documented in the resident's written record.

Failure to ensure the resident's written record was kept up to date at all times led to communication breakdown between staff and the resident's family about changes to the resident's plan of care.

Sources: Resident's clinical record, written complaint, interview with the home's physician.