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: October 21, 2024
Inspection Number: 2024-1346-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Waterdown Long Term Care Centre Inc.
Long Term Care Home and City: Alexander Place, Waterdown

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26 and 27, 2024, and October 1 - 4 and 7 - 11, 2024.

The following intake(s) were inspected:

- Intake: #00127505 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dietary services and hydration

NC #001 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 with a specific medical diagnosis and condition was to receive fluids thickened to nectar consistency according to their diet order and the master diet list (MDL).

The resident was observed in the dining room at a lunch meal. The resident was being fed their soup and the soup did not appear to be thickened. The Co-Director of Care was also in the dining room and confirmed that the soup was not thickened.

The resident's plan of care and nutritional risk assessment indicated specific risks associated with improper fluid consistencies. The Co-director of care and the Culinary manager confirmed that the resident was to receive thickened fluids.

Failure to ensure the resident received fluids thickened to a safe consistency based on their assessed needs increased their risk of negative outcomes, including choking and aspiration.

Sources: resident's clinical record, interviews with staff, observation of resident dining service.

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
The home's air temperature logs between September 16 – 30, 2024, showed that air temperatures were documented below 22 degrees Celsius. Specifically, on September 23, 24, 28, and 29, there were air temperature records that included readings of 19.3 and 20.6 degrees Celsius in designated cooling and dining room areas. This was also confirmed by a Registered Nurse, as well as the Director of Care (DOC) and the Environmental Services Supervisor.

Sources: Air temperature logs, and interviews with Registered Nurse, Environmental Services Supervisor and the DOC.

WRITTEN NOTIFICATION: Oral care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received oral care twice daily.

Rationale and Summary
A resident's PointClickCare (PCC) task records showed that they did not receive oral care twice daily on twelve different dates in a three month period. This was confirmed by a Personal Support Worker (PSW) who reviewed the resident's clinical records in the presence of the Inspector.

Sources: PCC task records, and interview with PSW.

WRITTEN NOTIFICATION: Quarterly evaluation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management

system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that the interdisciplinary team which met at least quarterly to evaluate the effectiveness of the medication management system in the home, included the Medical Director (MD).

Rationale and Summary
A review of the home's Professional Advisory Committee (PAC) Meeting notes showed that the Medical Director was not included on the attendance list. The DOC noted that the home's MD did not attend the quarterly meeting in which the effectiveness of the medication management system was evaluated.

Sources: Review of the home's PAC meeting, Medication Management Committee Meeting, and interview with the DOC.