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

# Public Report

**Report Issue Date:** December 23, 2024

**Inspection Number:** 2024-1346-0004

**Inspection Type:**
Critical Incident

**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): December 9, 10, 11, 13, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00119612 - Critical Incident (CI): 2861-000044-24 related to prevention of abuse and neglect.
- Intake: #00119911 - CI: 2861-000048-24 prevention of abuse, and neglect and resident care and support services.
- Intake: #00120341 - CI: 2861-000049-24 related to falls prevention and management.
- Intake: #00126547 - CI: 2861-000066-24 related to prevention of abuse and neglect.
- Intake: #00128244 - CI: 2861-000069-24 related to resident care and support services.
- Intake: #00128366 - CI: 2861-000073-24 related to prevention of abuse and neglect.
- Intake: #00128966 - CI: 2861-000076-24 related to prevention of abuse and neglect.
- Intake: #00130719 - CI: 2861-000080-24 relate to resident care and support services, and skin and wound management.

- Intake: #00131223 - CI: 2861-000082-24 related to prevention of abuse and neglect.
- Intake: #00131800 - CI: 2861-000083-24 related to prevention of abuse and neglect.

The following intake(s) were completed during this inspection:

- Intake: #00126060 - CI: 2861-000063-24 related to falls prevention and management.
- Intake: #00128446 - CI: 2861-000074-24 related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

# 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: O. Reg. 246/22, s. 34 (1) 4.**
General requirements

s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the home's Falls Program evaluation included a summary of the changes made and the date that those changes were implemented.

**Rationale and Summary**
The home's Falls Program evaluation for 2024 was reviewed during the inspection and did not include a summary of changes made to the program or the date any changes were implemented.

The Administrator updated the program evaluation and provided the missing information to the Inspector on December 16, 2024.

**Sources:** Falls Program evaluation, interview with Administrator.

Date Remedy Implemented: December 16, 2024

## WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 3 (1) 4.**
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:
4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that a resident's right to freedom from emotional abuse was fully respected and promoted.

Section 2 of Ontario Regulation (O. Reg.) 246/22, defines “emotional abuse” as (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

**Rationale and Summary**
On a specified date in September 2024, a staff provided care to the resident. The resident repeatedly refused care from this staff who continued to provide the care. Following the incident, the staff informed a registered staff that the resident stated that they would report the incident. The registered staff assessed the resident for injuries, and the resident stated that they were emotionally harmed. In the day following the incident, the resident continued to be emotionally upset, recounting the experience to other staff.

The home's investigation determined that the staff did not uphold the resident's rights.

Failure to ensure that the resident was free from emotional abuse, led to actual emotional harm.

**Sources:** Resident's progress notes, the home's investigation notes, interview with a Co-Director of Care (DOC).

## WRITTEN NOTIFICATION: Duty of 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.

A) The Licensee has failed to ensure the care set out in a resident's plan of care was provided to the resident as specified in the plan.

**Rational and Summary**
A resident was assessed upon admission with existing skin impairments. On a specified date in November 2024, the resident was re-assessed. At that time, they continued to present with skin issues.

Directions for care effective on a day in November 2024, included that staff were to complete a weekly Head to Toe Assessment under Assessments to monitor for any skin breakdown one time a day on a specified day.

A registered staff acknowledged the order and said the Head to Toe Assessment tool referred to is found under the assessments tab in Point Click Care (PCC). This registered staff and a Co-DOC reviewed documentation in PCC and said their assessments were not completed for two specified weeks in December 2024.

**Sources**: Resident's Head to Toe Assessments; Minimum Data Sheet (MDS) Assessments, Orders; Interviews with staff.

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

**Rational and Summary**
A resident's plan of care showed that they required two staff assistance for every aspect of their care. On a specified date in October 2024, a staff completed a task of providing assistance to the resident independently. The DOC acknowledged that the staff should have had another staff with them due to safety and behavioral concerns.

**Sources:** Resident's clinical records, the home's investigation notes, and Plan of Care policy, and interview with staff and the DOC.

## COMPLIANCE ORDER CO #001 Reporting certain matters to Director

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

1. Educate all Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW) and Agency 1:1 staff, who work on two specified resident home areas (RHA) on reporting requirements when there are reasonable grounds to suspect abuse of a resident by anyone. This

education should include what staff responsibilities are when an allegation of abuse is discovered and/or reported after hours, and;

2. Ensure that the education is held in person, and;
3. Ensure that there is a written record of who attended the education, the date(s) it was held, signatures that the staff understood the education and the name of the person(s) leading the education, and;
4. Provide the written record upon inspector request.

**Grounds**

A) The licensee has failed to ensure that alleged abuse of residents was immediately reported to the Director.

**Rationale and Summary**
According to Fixing Long-Term Care Act (FLTCA), 2021 s. 154 (3), the licensee is vicariously liable for staff members who fail to comply with FLTCA, 2021 s. 28 (1).

On a specified date in October 2024, a staff reported two incidents of alleged physical abuse by another staff towards two residents. One of the alleged incidents occurred on a day in September 2024 and the other occurred on a day in October 2024.

Review of the Critical Incident (CI) report indicated that it was first submitted to the Director on a later date in October 2024.

The DOC acknowledged that the report was not submitted immediately to the Director.

The staff failing to report the first incident of alleged abuse posed a risk of harm to residents.

**Sources:** CI report, home's investigation notes, interview with the DOC.

B) The licensee has failed to ensure that alleged abuse of a resident was immediately reported to the Director.

**Rationale and Summary**
The home submitted a CI on a specified date in September 2024, in the afternoon for an incident of alleged abuse that occurred earlier on that same day. A registered staff was made aware of the incident at the time it occurred and did not call an on-call manager or the Ministry of Long-Term Care's (MLTC) after-hours reporting line to report the incident. The registered staff made a progress note within the resident's record detailing the alleged abuse. The home became aware of the incident from later reading the 24-hour report and began their investigation. Improper care provided by a staff to the resident was substantiated by the home after their investigation.

Failure to immediately report alleged abuse had risk for the alleged abuse to continue before the home could intervene to put the staff on administrative leave while they conducted an investigation.

**Sources:** Resident's clinical record, CI report, interview with a co-DOC.

**This order must be complied with by** February 13, 2025.

**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

## 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.