

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 1, 2024

Inspection Number: 2024-1405-0002

Inspection Type:

Proactive Compliance Inspection

Licensee: Regency LTC Operating Limited Partnership, by its general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Willowgrove, Ancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10-13, 16-18, 2024.

The following intake(s) were inspected:

Intake: #00125749 related to a 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
- Residents' and Family Councils
- Food, Nutrition and Hydration
- Safe and Secure Home
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Quality Improvement

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

Staffing, Training and Care Standards
Residents' Rights and Choices
Pain 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. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

Rationale and Summary

During initial observation conducted on a specific date, two doors leading to non-residential areas were left opened and there were no staff in the immediate area supervising the rooms. These areas contained chemical products.

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

The home's Environmental Services Manager (ESM) was present at the time of observation; they indicated that these doors should not have been left open and immediately closed them.

Sources: Observation and discussion with ESM.

Date Remedy Implemented: September 10, 2024

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 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 report an alleged incident of staff to resident emotional abuse to the Director.

Pursuant to s. 154 (3) of the FLTCA 2021, the licensee is vicariously liable to staff members failing to comply with section 28 (1).

Rationale and Summary

During an interview with staff, they acknowledged that upon becoming aware of an alleged incident of emotional abuse by another staff against a resident, they did not

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

report the incident to the management team or the Ministry's after-hour Infoline.

The home's Abuse Free Communities – Prevention, Education, and Analysis Policy stated that the home have zero tolerance with respect to failure to report abuse of any kind, and that all residents should be treated with courtesy and respect at all times.

Sources: The home's "LTC-ON-100-05-01 Abuse Free Communities – Prevention, Education and Analysis Policy" revised July 2024; Interview with staff.

WRITTEN NOTIFICATION: Air temperature

NC #003 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 showed documented air temperature below 22 degrees Celsius for several days in August and September 2024. There were air temperature records that included readings between 19.8 and 21.2 degrees Celsius in resident rooms and common areas.

The home's policy, "Heat Risk and Cold Weather Precautions" required the home's temperatures to be maintained at a minimum 22 degrees Celsius. This was also acknowledged by staff and the home's Environmental Services Manager (ESM).

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

Sources: Air temperature logs, the home's policy, "LTC-ON-200-07-05: Heat Risk and Cold Weather Precautions" revised July 2024; Interview with staff.

WRITTEN NOTIFICATION: Oral care

NC #004 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 resident was offered mouthcare during morning care on four different days.

Rationale and Summary

Resident's PointClickCare (PCC) tasks record showed that they did not receive oral care as required on multiple days. This was acknowledged by PSW who reviewed the resident's clinical records in the presence of the Inspector and stated that there was no documentation to support that the resident received mouthcare on these specific days.

Sources: PCC tasks records; Interview with staff.

WRITTEN NOTIFICATION: Skin and wound

NC #005 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,

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

(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 has failed to ensure that resident who exhibited an altered skin integrity on their hip, was reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

Rationale and summary

Resident developed an altered skin integrity on their hip and the initial skin assessment was completed the same day. Further weekly skin and wound assessments under the assessment tab in PointClickCare (PCC) did not include a re-assessment of the altered skin integrity to indicate their condition/progression.

Staff confirmed that weekly skin and wound assessments for the altered skin integrity was not completed as required for over two weeks. Staff stated that the wound healed.

Failing to reassess the altered skin integrity at least weekly increased the risk of ineffective wound treatment of the resident.

Sources: Weekly skin and wound assessments tab in PCC; Interview with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

Nutritional care and hydration programs

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

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to ensure they complied with a procedure in their nutritional care and hydration program related to dietary services.

Rationale and Summary

In accordance with O. Reg. 246/22 s. 11 (1) b the licensee was required to ensure the nutritional care and hydration program had in place policies and procedures related to dietary services.

Specifically, staff did not comply with the Food Temperature Policy which directed food service workers to take and record food temperatures once food was placed on/in the hot top/steam table, on the Food Temperature Sheet.

The food temperature log did not include the breakfast food temperature for two Resident Home Areas (RHA) on an identified date. The breakfast menu listed puree toast, hot cereal, puree hot cereal and puree entree.

Executive Director (ED) acknowledged that the food temperature was not recorded as required that day for breakfast on both RHAs.

Failing to check and record food temperature placed residents at risk of receiving food that was overheated and dietary staff may not have been able to identify and adjust food temperature issues before serving residents their meal.

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

Sources: Food temperature log; Food Temperature Policy (Revised August 2024);
Interview with ED.