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: March 20, 2025

Inspection Number: 2025-1346-0001

Inspection Type:
Complaint
Critical Incident
Follow up

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): March 12-14, 17-20, 2025.

The following intake(s) were inspected:

- Intake: #00133151 - Complaint with concerns regarding medication management, residents' rights and choices.
- Intake: #00135304 - Follow-up #: 1 - Compliance Order (CO) #001/2024-1346-0004, - FLTCA, 2021 - s. 28 (1) 2 Reporting certain matters to the Director, Compliance Due Date (CDD) March 13, 2025.
- Intake: #00135353 - Critical Incident (CI): 2861-000089-24 - Falls prevention and management.
- Intake: #00135776 - CI: 2861-000091-24 - Infection prevention and control.

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

- Intake: #00138312 - CI: 2861-000004-25 related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1346-0004 related to FLTCA, 2021, s. 28 (1) 2.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident received a skin assessment upon their return from hospital.

Sources: Resident's skin & wound assessments, progress notes, and interview with Registered Staff.

WRITTEN NOTIFICATION: Medication management system

NC #002 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 has failed to ensure that their policies for the medication management system were implemented.

In accordance with Ontario Regulation (O. Reg.) 246/22, s. 11 (1) (b), the licensee is required to ensure that the written policies developed for the Medication management system were complied with.

Specifically, the home's policy indicated that when receiving medications, the pharmacy reports should be signed and dated as part of the drug record, and be filed either in the primary Drug Record or in a separate Drug Record. This was not done for two identified home areas.

Sources: Interview with Registered Staff, the home's policy "Policy 6, Silver Fox Pharmacy".

WRITTEN NOTIFICATION: Safe storage of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,

(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart when controlled substances were delivered from the pharmacy and were left in the medication room on an identified home area and/or at the nurses' station.

Sources: Interviews with Registered Staff, the home's policy "LTC Narcotics and Controlled Substances".