

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: October 28, 2025
Inspection Number: 2025-1346-0007
Inspection Type: Complaint 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): October 14, 16, 17, 20, 21, 22, 23, 27, 28, 2025

The inspection occurred offsite on the following date(s): October 22, 2025

The following intake(s) were inspected:

-Intake: #00158223 - Critical Incident (CI) 2861-000043-25 - related to medication management.

-Intake: #00159699 - Complaint related to skin and wound care and resident care and support services.

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

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Medication Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 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 that the care set out in the plan of care for a resident was complied with as specified in their plan.

On a specified date in October 2025, a resident was assessed by a registered staff who documented that they exhibited an elevated result related to a specified diagnosis that was being monitored. The physician's order directed that if an elevated result was measured during a specified time period of the day, staff was to notify the Medical Director (MD). The registered staff acknowledged that they did not contact the MD.

Sources: Resident clinical records; interview with the Director of Care (DOC), MD, and a registered staff.

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 123 (3)

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
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director.

The licensee failed to ensure that the home's policies related to their medication management system was implemented.

According to Ontario Regulations (O.Reg.) 246/22, s. 11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or system, the licensee is required to ensure that the policy or system is complied with.

The home's policy directed registered team members to evaluate the appropriateness of the prescribed medication for the resident and discuss any concerns with the prescriber prior to administration of the medication, and to clarify any incomplete, inappropriate and or misunderstood orders with the prescriber.

On a date in September 2025, a change in direction for a medication of a resident was prescribed incorrectly. The involved registered staff acknowledged that they questioned the order but did not seek clarification. The resident thus received the wrong dosage of the medication resulting in a transfer to hospital for further assessment.

Sources: Resident clinical records, the home's investigation notes, the home's policies: LTC Physician Orders- Written, Verbal & Telephone, last review date 2025-

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08-23, and LTC Physician Orders- Transcription (Routine and Stat Orders), last review date 2025-08-23, interview with a registered staff.

COMPLIANCE ORDER CO #001 Required programs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

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:

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

a) Review and re-educate three specified registered staff on the home's Skin and Wound Care Program, including but not limited to their roles and responsibilities; how to utilize the assessment tool(s) that are available appropriately; the importance of completing assessments accurately for all altered skin integrities; and appropriate action to be taken if concerns are identified.

b) Document and maintain a record of the review and re-education provided, including the date and time, the name of the person who provided the review/re-education, the name of the staff who participated, including their role and signatures, and the materials covered within the review/re-education.

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c) Conduct one audit of all assessments completed for all residents who may be exhibiting pressure injuries in the home for completion and accuracy, and implement an action plan for any identified concerns.

d) Document and maintain a record of this audit, including the date and time, the name of the person who conducted the audit and the action plan implemented for identified concerns.

e) Have all records available for Ministry of Long-term Care Inspector review.

Grounds

The licensee failed to ensure that the home's skin and wound care program was implemented.

According to O.Reg. 246/22, s.11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have or otherwise put in place a program, the licensee is required to ensure that the program is complied with.

The home's program indicated that a resident with actual alteration in skin integrity is to be assessed at least weekly using the Skin and Wound Module through Point Click Care (PCC) by use of an IPOD, and all documentation is required in order to complete the wound assessment. The program also stated that the completion of this form will serve as the referral to the skin and wound care lead of the resident's change in skin integrity and/or treatment, and will receive prompt treatment and interventions to prevent infection.

On a day in August 2025, a resident's skin assessment for an identified wound had an inconsistent and incomplete assessment. On a day in September 2025 the

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assessment for the specified wound was also incomplete as neither of the assessments contained all of the required documentation within the tool and their associated progress notes. The missing information within the assessments included the description of the wound bed, exudate, peri-wound and wound pain. A Wound Care Lead acknowledged that the assessments were incomplete.

On another date in September 2025, there was no weekly skin assessment completed for the specified wound and on another date in September, two weeks after the last assessment, a weekly skin assessment was completed which indicated that the wound had further deteriorated. This prompted a referral to the home's Nurse Practitioner (NP) and a communication with an external resource.

Failure to complete weekly wound reassessments may have impacted the ability of staff to determine if a referral to the skin and wound care lead was required earlier in order to prompt necessary interventions and possible treatment for the resident's wounds.

Sources: Resident clinical records, interview with a Wound Care Lead, DOC, Wound Care Specialist and NP, and review of LTC Skin and Wound Care Program, revised 11/03/2025.

This order must be complied with by November 18, 2025

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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

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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:

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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.