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

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Public Report

Report Issue Date: March 2, 2026
Inspection Number: 2026-1346-0001
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 dates: February 19-20, 23, 25-27, 2026 and March 2, 2026.

The inspection occurred offsite on the following date: February 24, 2026.

The following intake was inspected:
- Intake: #00169823 was related to a Proactive Compliance Inspection.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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.

A. A resident's plan of care specified they required extensive to total assistance with meals. A review of the documentation showed that the resident received independent/set up help or supervision the majority of the time.

Sources: observations; resident's clinical records, LTC Meal Service Policy; and interviews with staff.

B. A resident's plan of care specified they needed an adaptive device, to drink fluids. Inspector observed a regular plastic cup on the resident's bed side table. A staff member said that they have often seen regular plastic glasses in the resident's room.

Sources: observation; resident's clinical records; and interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours - Triggers

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible;

Documentation revealed a resident expressed responsive behaviours towards a co-resident during a specific situation. The resident's plan of care did not identify any known triggers associated with that specific situation for responsive behaviours.

Sources: resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Review of the Dementia Observation System (DOS) for three residents revealed incomplete documentation.

Sources: three resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

In accordance with O. Reg. 246/22, s. 11 (1)(b), the licensee is required to ensure that written policies developed for the hydration program were complied with. Specifically, the home's hydration policy indicated that a dietary referral be made when a resident consumed less than 750 ml fluids for three consecutive days. A resident's fluid intake was below 750 ml on three consecutive days; however, the dietary referral was late.

Sources: resident's clinical records, Hydration Assessment and Monitoring; and interview with staff.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

A resident's plan of care specified extensive to total assistance with meals. When the resident received their meal, staff were not present to provide meal assistance.

Fifteen minutes later, a staff member cut up the meal and began feeding the resident.

Sources: observations; LTC Meal Service Policy; and interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A. Section 9.1 (b) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes specified that the four moments of hand hygiene included before initial resident contact and after.

During lunch medication pass, a registered staff member did not consistently perform hand hygiene prior to and after resident contact.

Sources: observations; IPAC Standard for Long-Term Care Homes, and Hand Hygiene Program.

B. Section 9.1 (d) of the IPAC Standard for Long-Term Care Homes specified Proper use of PPE, including appropriate selection, application, removal, and disposal.

Additional Personal Protective Equipment (PPE) requirements including appropriate

selection and application of face protection were not met when staff provided care to a resident on additional precautions.

Sources: observations and interviews with staff.