Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
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Public Report

Report Issue Date: July 24, 2025
Inspection Number: 2025-1275-0003
Inspection Type: Critical Incident
Licensee: DTOC III Long Term Care LP by its general partner, DTOC III Long Term Care MGP (a general partnership), by its partners, DTOC III Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: The Wellington Nursing Home, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15-17 and 22-24, 2025.

The following intake(s) were inspected:

- Intake: #00149992 - Critical Incident (CI) - 2784-000010-25 - Related to Infection prevention and control.
- Intake: #00151929 - Critical Incident (CI) - 2784-000011-25 - Related to Infection prevention and control.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed of an outbreak declared by Public Health on a day in June, 2025, when they reported three days after the outbreak had been declared.

Sources: Critical incident report, interviews with the Infection Prevention and Control Lead and the Director of Care.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief

Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that the recommendations issued by the Chief Medical Officer of Health were followed in the home. On a day in July, 2025, two alcohol based hand rub (ABHR), was observed to be expired. The Director of Care and the Infection Prevention and Control Lead acknowledged that the ABHR were expired and should be discarded.

Sources: Chief Medical Officer of Health (CMOH) recommendations for outbreak prevention and control in institutions and congregate settings, observations of hand sanitizer dispenser, interviews with staff, the Director of Care and the Infection Prevention and Control Lead.