

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: December 11, 2025

Inspection Number: 2025-1363-0006

Inspection Type:

Critical Incident

Licensee: Steeves & Rozema Enterprises Limited

Long Term Care Home and City: Westmount Gardens Long Term Care Home,
London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 9-11, 2025

The following intake(s) were inspected:

- Intake: #00163367 - CI #2878-000081-25: Alleged neglect to resident.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

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Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

Resident did not receive essential care, during the shift on a specific day. Staff documentation indicated that the care had been provided. However, video evidence reviewed by the management team in the home indicated that staff did not deliver care, resulting in inaccurate documentation and care records.

Sources: Resident's clinical record reviews; Review of home's investigation notes and Critical Incident Report; Interviews with staff members.

WRITTEN NOTIFICATION: Continence care and bowel management

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

Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

Resident did not receive incontinence care during the shift. Documentation completed by staff member indicated assistance had been provided for each episode. However, home's investigation evidences indicated that staff did not enter the resident's room to deliver care or perform checks.

Sources: Resident's clinical record reviews and documentation; Review of home's

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investigation notes and Critical Incident Report; Interviews with staff members and resident.

WRITTEN NOTIFICATION: Menu planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 77 (4) (a)

Menu planning

s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;

Resident did not receive their scheduled meal on a specific shift. Documentation completed by staff member indicated that the resident consumed their meal with fluids, however stated that they did not recall resident being in the dining room or receiving tray service. Home's investigation evidences indicated staff did not assist the resident to the dining room or provide tray service in their room.

Sources: Resident's clinical record reviews and Point of Care documentation;
Review of home's investigation notes and Critical Incident Report; Interviews with staff members and resident.