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

# Amended Public Report Cover Sheet (A1)

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| **Amended Report Issue Date:** September 9, 2025 |
| **Original Report Issue Date:** July 10, 2025 |
| **Inspection Number:** 2025-1708-0003 (A1) |
| **Inspection Type:**<br>Complaint<br>Critical Incident |
| **Licensee:** Partners Community Health |
| **Long Term Care Home and City:** Wellbrook Place West, Mississauga |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #002, #005, and #006 have been rescinded from this report, as it has been substituted with Director's Order (DO) #001. CO #004 has been rescinded. WN #025 is being newly issued in this Amended Inspection Report. Compliance Order #001, #003, and #007 are included in this report for reference; however, were not amended; therefore, the served date remains July 10, 2025.

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## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 30, May 1-2, 5-9, 13-16, 20, 22-23, 26-30, and June 2-4, 6, 9-10, 2025.
The inspection occurred offsite on June 5, 2025.

The following intake(s) were inspected:
-Intake: #00137918, CIS #3067-000014-25 was related to Prevention of Abuse and Neglect.
-Intake: #00138696, was a complaint related to Resident Care and Support Services.
-Intake: #00140858, CIS #3067-000025-25 was related to Falls Prevention and Management.
-Intake: #00140861, was a complaint related to Infection Prevention and Control (IPAC), and Resident Care and Support Services.
-Intake: #00141003, was a complaint related to Resident Care and Support Services.
-Intake: #00142119, was a complaint related to Resident Care and Support Services, Medication Management, and Falls Prevention and Management.

-Intake: #00143861, CIS #3067-000031-25 was related to Falls Prevention and Management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Pain Management
Falls Prevention and Management

# AMENDED INSPECTION RESULTS

## WRITTEN NOTIFICATION: Based on assessment of resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (2)**
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that a resident's bladder continence status was based on assessment of the resident, as the plan of care and MDS reflect different continence statuses for the resident.

**Sources:** A resident's plan of care, Minimum Data Set (MDS); and interview with staff.

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan related to falls.

The resident's plan of care indicated that the resident was assessed to be at high risk for falls and one of the interventions was ensuring that a device was in place. During the inspection, the device was not in place and the staff were not aware the resident required the device.

**Sources:** Observations; a resident's assessments, care plan and kardex; interviews with staff.

B) The licensee has failed to ensure that the plan of care for a resident was provided to the resident as per the plan related to toileting.

The resident's plan of care indicated that the resident was to be changed in a specified location with the assistance of two staff. The plan for the resident was not followed for a specified timeframe when they were being toileted instead of changed in the specified location.

**Sources:** A resident's plan of care, home's investigation notes; interview with staff.

C) The licensee has failed to ensure that the care set out in the plan was provided to a resident when staff offered the resident a dietary option that was not requested by the resident as per the plan.

**Sources**: Observation; a resident's plan of care, progress notes, meal suite on device, menu cycles; interview with staff.

## WRITTEN NOTIFICATION: Nursing and personal support services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 11 (1) (b)**
Nursing and personal support services
s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

The licensee has failed to comply with the organized program of personal support services for the home to meet the assessed needs of the residents when an assistive device was not applied on a resident's wheelchair.

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

Specifically, the home failed to comply with their Use of Wheelchairs policy when the staff failed to apply an assistive device to the resident's wheelchair.

**Sources:** A resident's health records, home's Use of Wheelchairs policy; interview with staff.

## WRITTEN NOTIFICATION: Policy to minimize restraining of residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 33 (1) (b)**
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

A) The licensee has failed to comply with the home's policies related to Physical Restraints and Personal Assistive Safety Devices (PASD), pertaining to the reassessment of a PASD, that stated a PASD assessment was to be completed prior to the application of the PASD, in addition to quarterly, annually or with a significant change of status.

A PASD was implemented for a resident. An initial restraint/PASD assessment was

completed prior to the implementation of the PASD; but there were no additional assessments until 10 months after the initial assessment.

**Sources:** A resident's care plan, Restraint/PASD Assessments, Point Click Care (PCC) Restraint/PASD Assessment History, Partners in Community Health Physical Restraints and Personal Assistive Safety Devices Policy; interviews with staff.

B) The licensee has failed to comply with the home's policy related to Physical Restraints and PASD, that stated a PASD assessment was to be completed prior to the application of the PASD.

Specifically, the staff failed to comply with the home’s Physical Restraints and PASD policy when a resident was not assessed for the use of a mobility device as a PASD, prior to the use of the device.

**Sources:** Observations; a resident's plan of care, home's Physical Restraint and Personal Assistive Safety Device policy; interviews with staff.

## WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.**
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

The licensee has failed to ensure that the plan of care for a resident was based on, at a minimum, interdisciplinary assessment of the safety risks related to the use of a transfer device.

The resident was not assessed for the transfer device that was being used to transfer the resident.

**Sources:** Observations; manufacturer's instructions for the transfer device, a resident's plan of care; interviews with staff.

## WRITTEN NOTIFICATION: Nursing and personal support services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 35 (4)**
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to keep a written record related to staffing evaluation for 2024 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

**Sources:** Interview with staff, and email confirmation by staff.

## WRITTEN NOTIFICATION: Bathing

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 37 (1)**
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, with no medical contraindications.

**Sources**: A resident's bathing records; interview with staff.

## WRITTEN NOTIFICATION: Mobility devices

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 43**
Mobility devices
s. 43. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis.

The licensee has failed to ensure that mobility devices were available to a resident when required for a short-term period of seven days. Due to the lack of an available mobility device, a resident was confined to bed. Staff confirmed that the home did not have any loaner mobility devices for temporary use by residents.

**Sources**: A resident's plan of care; interview with staff.

## WRITTEN NOTIFICATION: Availability of supplies

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 48**
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The licensee has failed to ensure that equipment, such as a device for toileting, was readily available in the home to meet any resident's nursing and personal care needs. As per care plan, a resident was to use a device for toileting. A staff member confirmed that a device for toileting must be ordered from an external vendor, with a typical wait time of seven to ten days for delivery.

**Sources:** A resident's plan of care, progress notes; interview with staff.

## WRITTEN NOTIFICATION: Required programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.**
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:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that a resident was assessed for pain when they complained of pain for two days.

In accordance with Ontario Regulations (O.Reg.) 246/22, s. 11 (1) (b), where the Act or this Regulation required the licensee of a long-term care home to have in place any program, the licensee was required to ensure that the program was complied with.

Specifically, staff did not comply with the home's Pain Management Program when the resident complained of pain, and a pain assessment was not completed. The resident continued to experience pain and exhibited non-verbal pain for two days. The Nurse Practitioner (NP) was not called for further assessment until two days after the initial complaint of pain. The resident was sent to the hospital and diagnosed with an injury.

**Sources:** A resident's plan of care, home's Pain Management Program; interview with staff.

## WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (1) 2.**
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

The licensee has failed to comply with the home's Skin and Wound Care program, when assessments of a resident's wound, did not include completion of all sections of the wound assessment on two assessments.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the Skin and Wound Care program was complied with. Specifically, the home did not comply with their Wound Care Policy in their Skin and Wound Care program, which identified all the areas that were to be included in the wound assessment.

**Sources:** A resident's progress notes, Skin and Wound Assessments, the home's Wound Assessment and Documentation policy; interview with staff.

## WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.**
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

A) The licensee has failed to ensure that staff complied with the home's dining and snack service that included a procedure to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs, and preferences, when staff served snacks without referencing residents' Point of Care (POC)/meal suite profile for special diets and preferences.

In accordance with Ontario Regulations O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the procedure for staff to utilize the POC/meal suite with residents' diet preferences and special diet considerations for meals and snacks was complied with.

Specifically, a staff member failed to comply with the home's procedure to use the POC during snack service for residents when the staff member began snack service without referencing the POC for several residents.

**Sources:** Observation; POC; interview with staff.

B) The licensee has failed to ensure that the home's dining and snack service that included a procedure to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs, and preferences was complied with when the dietary meal suite profile for a resident was missing special dietary information.

In accordance with Ontario Regulations O. Reg. 246/22, s. 11 (1) (b), In accordance with Ontario Regulations O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the procedure for meal suite profile for a resident at the point of service, included the special diet considerations as per plan of care.

Specifically, the procedure of the home for dietary staff to use the meal suite for meal service was not complied with when a resident's special consideration to their food and nutrition plan for meals on their plan of care, was missing on the meal suite device which was used as a reference point for dietary service during dining room service.

**Sources:** Observation; meal suite device, plan of care; interview with staff.

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 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) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was complied with, when a staff member did not observe hand hygiene before entering a resident’s room, setting up the tray on the resident's table, and after exiting the resident’s room during tray service.

Section 9.1 (b), of the IPAC Standard, specified that the home’s hand hygiene shall include, but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

The home’s Hand Hygiene policy named the Hand Hygiene Standards also stated that hand hygiene should be observed before initial contact with a resident or items in their environment; this should be done upon entry to the room or bed space, even if the resident has not been touched; after contact with a resident or items in their immediate surroundings when leaving, even if the resident has not been touched.

**Sources**: Observation; Hand Hygiene policy-Hand Hygiene Standards; interview with staff.

B) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with, when a staff member went into a resident on droplet/contact room and provided care to resident without wearing a face shield.

Section 9.1 (f), of the IPAC Standard, specified that additional precautions shall include additional personal protection equipment (PPE) requirements including appropriate application and removal.

When entering/exiting residents room under droplet/contact precautions for a respiratory virus, during a suspect outbreak, the staff member did not don a face shield while entering the resident's room and provided care to the resident.

**Sources**: Observation; IPAC standard, PPE policy; interview with staff.

C) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with, when multiple staff, did not provide more than half of the residents in the dining room with hand hygiene prior to serving residents lunch in the dining room.

Section 10.4 (h) and (i), of the IPAC Standard, specified that the home's hand hygiene program shall include policies and procedures to support residents to perform hand hygiene prior to receiving meals, including those who have difficulty to complete hand hygiene due to mobility, cognitive or other impairments.

**Sources**: Observation; IPAC standard, Hand Hygiene policy; interview with staff.

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.**
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):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible, for a resident's sudden or unexpected death as confirmed by staff.

**Sources**: A resident's progress notes; interview with staff.

## WRITTEN NOTIFICATION: Administration of drugs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (2)**
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident's medications were not administered to the resident as prescribed by the physician.

**Sources:** Review of resident's plan of care; interview with staff.

## WRITTEN NOTIFICATION: Residents Drug Regimes

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 146 (a)**
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee has failed to monitor and document the effectiveness of a medication administered to a resident.

The resident was administered pain medication. The effectiveness and the resident's response to the medication was not monitored or documented.

**Sources**: A resident's progress notes, Pain Level Assessment History, Partners in Community Health Pain Management Program policy.

## WRITTEN NOTIFICATION: Resident records

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 274 (b)**
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident’s written record is kept up to date at all times.

The licensee has failed to ensure that a resident's records were kept up to date, as a specific diagnosis was missing from the PCC system. A staff member stated that missing diagnoses can pose a risk to residents, as care plans and other assessments rely on the diagnosis of the resident.

**Sources:** A resident's progress notes, review of medical diagnosis in PCC and interviews with staff.

## COMPLIANCE ORDER CO #001 Duty to protect

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall ensure that residents are protected from abuse by anyone and shall

ensure that residents are not neglected by the licensee or staff.

Specifically, the licensee shall:
1-For a period of three weeks following the service of this report, maintain a list of residents on an identified home area who have changes in condition. Complete a weekly audit to ensure that actions are being taken related to the changes.

2-Include any remedial actions taken if any discrepancies are noted in the audits.

**Grounds**

A) The licensee has failed to ensure that a resident was not neglected by staff.

Ontario Regulation 246/22, s. 7, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A resident was neglected by staff when a skin impairment, present on admission, did not have a skin and wound assessment completed, and there was a delay in providing treatment to the skin impairment.

The skin impairment was not assessed at a minimum weekly by a registered staff, and two assessments were not completed fully as per the home's policy, and were missing important information. When there was a change in the condition of the skin impairment, the resident was not provided immediate treatment and interventions.

Further to this, there were medication changes made following a change in the resident's condition. The home's policies related to medication management were not followed, including timely processing of the orders, and authentication of a telephone order by the doctor at the earliest opportunity. This resulted in medication errors whereby the resident did not receive their medication for multiple days.

This pattern of inaction jeopardized the resident's health and well-being. Their condition deteriorated, and they were sent to the hospital, where they were diagnosed with a medical condition, and where they subsequently passed away.

**Sources:** A resident's progress notes, Skin and Wound Assessments, Physician's DigiOrders, Medication Administration Record (MAR), Treatment Administration Record (TAR), Care Plan, the home's Wound Assessment and Documentation policy, Physician's Orders policy, Manual for Medisystem, Policies and Procedures; interviews with staff.

B) The licensee has failed to ensure that a resident was protected from physical abuse by another resident, when a resident used physical force on another resident which resulted in an injury to the resident.

Ontario Regulation 246/22, s. 2, defined physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

**Sources**: A resident's progress notes, Skin and Wound Assessments, Head to Toe Assessments, Physical Aggression Resulting in Injury documentation; interviews with staff.

**This order must be complied with by** September 19, 2025

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Compliance Order CO #001**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $16500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**

In the past 36 months, a CO under FLTCA, 2021, s.24 (1) was issued (#2025-1708-0002) on April 4, 2025, and resulted in a $11,000 AMP.

This is the third AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

**(A1)**
**The following order(s) has been rescinded: CO #002**
**The following order(s) has been substituted: DO #001**

## COMPLIANCE ORDER CO #002 Skin and wound care

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

## COMPLIANCE ORDER CO #003 Medication management system

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 123 (2)**
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall ensure that written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home, are complied with.

Specifically, the licensee shall:
1-Re-train registered staff on an identified home area on their Physician's Orders policy, including review, acknowledgement, and execution of Physician's Orders in a timely manner.

2-Re-train registered staff on an identified home area on their Order Components policy, and actions staff need to take when all of the Order components are not in place; which include but not limited to, a resident's health card number, the strength of the medication, and the route of administration.

3-Re-train prescribers on an identified home area on their Telephone and Verbal Orders policy, including authenticating telephone and verbal orders at their next visit or at the earliest opportunity.

4-Re-train an identified registered staff on their Physician's Orders policy, specifically related to actions to take when orders need clarification.

5-Re-train registered staff on an identified home area on the home's policy related to documenting the administration of medication in the eMAR. Provide specific education related to PRN (pro re nata) or as needed medications, medications filled over the weekend/after hours and medications provided from the emergency supply box.

6-Maintain a written record of training provided, the date of training, name of staff attending with signature indicating understanding of training received, and the staff providing the education.

7-For a period of three weeks following the service of this report, assign a designated person to complete weekly audits to ensure that:
a- All residents on an identified home area with new Physician's Orders have their orders reviewed, acknowledged, and executed by registered staff in a timely manner;
b- All new orders on an identified home area have all the Order components in place;
c- All telephone orders given by prescribers on an identified home area authenticate the telephone order at their next visit or at the earliest opportunity.

8-Document the weekly audits, and include resident name, date of audit, names of registered staff involved, names of prescriber involved, any gaps identified, and actions taken if any discrepancies are noted in the audits.

9-From the service of this report to the compliance due date; ensure all physician's orders being processed by a specific registered staff are supervised and monitored. Document that this supervision and monitoring was completed, by whom, and any gaps identified, and actions taken as a result.

10-Keep all records.

**Grounds**

A) The licensee has failed to comply with the home's medication management system when a physician's order for a resident was not clear and the registered staff failed to clarify the order and discontinued a high alert medication.

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

Specifically, registered staff failed to comply with the home's Physician Orders policy, when they did not clarify a physician's order for a high alert medication, which was not clear and they stopped the order. As a result the resident did not receive their medication dose for multiple days.

**Sources:** A resident's health records, home's Physician Orders policy; interviews with staff.

B) The licensee has failed to comply with the home's medication management system when Physician's Orders for a resident, were not reviewed, acknowledged, and executed by Registered Staff in a timely manner.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the Medication Management system were complied with. Specifically, the home did not comply with the Physician's Orders policy, which stated that all orders prescribed by a physician must be reviewed, acknowledged, and executed by Registered Staff in a timely manner to ensure the best outcome for the resident. This policy was not followed for four different orders that were given by the doctor following the resident's change in condition.

Staff members confirmed that the orders should be processed before the first dose that the medication was due to be administered. By not following their policy, a staff member confirmed a chain of events where orders were not transcribed into the eMAR before a new order was written; and a medication error occurred, resulting in the resident not being administered their medication for multiple days.

**Sources:** A resident's progress notes, Physician's DigiOrders, MAR; Physician's Orders policy, Medication Incident Report (MIR); interviews with staff.

C) The licensee has failed to comply with the home's Medication Management system when a physician's order was missing the resident's health card number, the strength of the medication, and the route of administration.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies, and procedures developed for the Medication Management system were complied with. Specifically, the home did not comply with the Order Components section of the Manual for Medisystem Policies and Procedures, which stated that all orders must contain a resident's health card number, the name and strength of the medication, and the route of administration.

**Sources:** A resident's Physician's DigiOrders, MAR, Manual for Medisystem, Policies

and Procedures; interviews with staff.

D) The licensee has failed to comply with the home's Medication Management system when a telephone order for a high alert medication was not authenticated at all by the prescriber, when it was supposed to be done at their next visit or at the earliest opportunity.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies, and procedures developed for the Medication Management system were complied with. Specifically, the home did not comply with the Telephone and Verbal Orders section of the Manual for Medisystem Policies and Procedures, which stated that the prescriber would authenticate telephone and verbal orders at their next visit or at the earliest opportunity.

Failure to follow the home's policy of authenticating the order, which was supposed to be done at the earliest opportunity, put the resident at an even higher risk of a medical condition that the medication was ordered to address. It resulted in the resident not receiving their medication for multiple days.

**Sources:** A resident's progress notes, Physician's DigiOrders, MAR, Manual for Medisystem, Policies and Procedures; interviews with staff.

E) The licensee has failed to comply with the home's policies related to the Medication Management System, when the administration of medication to a resident was not documented in the eMAR.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and procedures developed for the Medication Management System were complied with. Specifically, the home did not comply the medication administration section of the policy which stated the eMAR was to be initialed for each medication administered, when a high alert medication that was administered to a resident was not documented in the eMAR.

**Sources**: A resident's progress notes, eMAR, Manual for MediSystem Serviced Homes, MAR; interview with staff.

**This order must be complied with by** September 19, 2025

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #002**
**Related to Compliance Order CO #003**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**

In the past 36 months, a CO under O. Reg. 246/22, s. 123 (2) was issued (#2024-1708-0003) on August 29, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

**(A1)**
**The following order(s) has been rescinded: CO #004**

## COMPLIANCE ORDER CO #004 Plan of care

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 6 (5)**
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

**(A1)**
**The following order(s) has been rescinded: CO #005**
**The following order(s) has been substituted: DO #001**

## COMPLIANCE ORDER CO #005 Skin and wound care

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

**(A1)**
**The following order(s) has been rescinded: CO #006**
**The following order(s) has been substituted: DO #001**

## COMPLIANCE ORDER CO #006 Skin and wound care

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

## COMPLIANCE ORDER CO #007 Additional training — direct care staff

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.**
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall ensure that all the direct care staff complete the mandatory annual training related to Skin and Wound Care.

Specifically, the licensee shall:
1-Train all the direct care staff who were not trained in 2024 related to the home's Skin and Wound Care program.

2-Maintain a written record of training provided, the date of training, name of staff attending with signature indicating understanding of training received, and the staff providing the education.

**Grounds**

The licensee has failed to ensure that all staff who provided direct care to residents

received training in Skin and Wound Care in 2024, when the home only had 79% of direct care staff trained.

**Sources:** Skin and Wound Training Record-Surge Report 2024; interview with staff.

**This order must be complied with by** September 19, 2025

**(A1)**
**The following non-compliance(s) has been newly issued: NC #025**

## WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (5)**
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's SDM was given an opportunity to participate fully in the development and implementation of a resident's plan of care, when the home did not notify them of changes in the resident's condition, when the resident's decision making was impaired.

The resident's Power of Attorney (POA) identified that they were unaware of changes in the resident's condition and wanted to know what happened to the resident before they passed away.

**Sources:** A resident's progress notes, Skin and Wound Assessments, Physician's DigiOrders; and interview with staff.

## 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
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:

**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.