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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: October 9, 2025
Inspection Number: 2025-1708-0006
Inspection Type:
Complaint
Critical Incident

Licensee: Partners Community Health
Long Term Care Home and City: Wellbrook Place West, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1-2, 6-9, 2025.

The following intake(s) were inspected:
-Intake #00148761 - Complaint related to resident care and support services
-Intake #00151267 - Critical Incident (CI) #3067-000044-25 related to falls prevention and management
-Intake #00155091 - Complaint related to resident care and support services
-Intake #00155153 - CI #3067-000058-25 related to resident care and support services
-Intake #00155404 - Complaint related to resident care and support services

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

Resident Care and Support Services
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in a falls risk and screening assessment, so that their assessments were integrated and consistent with and complemented each other. Risk factors to falls were not identified in a Falls Risk Screening, Assessment and Management assessment completed as identified in other assessments and records related to the resident.

Sources: Resident clinical records and interview with staff.

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that all direct care staff were kept aware of the contents of a resident's plan of care. An assessment indicated that a resident required a certain intervention at all times and their care plan did not indicate this intervention until four months later. A staff member acknowledged that certain direct care staff did not have access to the assessment.

Sources: A resident's clinical record, interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 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 must be based, on a minimum, interdisciplinary assessment with respect to safety risks.

A resident's family member informed staff during a conversation of a safety risk. There was no documentation of this discussion in the resident's clinical record or any assessments completed related to the identified safety risk.

Sources: A resident's clinical record, an e-mail and interview with staff.

WRITTEN NOTIFICATION: Resident records

NC #004 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 written record was kept up to date at all times, when a diagnostic report completed in 2024 was not included in the record until 2025.

Sources: Review of the clinical health record of a resident, a diagnostic report and interview with staff.