Public Report

Report Issue Date: January 9, 2026
Inspection Number: 2025-1708-0008
Inspection Type:
Complaint
Critical Incident
Director Order Follow Up (DOFU)

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): December 15, 16, 18, 19, 22, 23, 29, 30, 31, 2025 and January 5-9, 2026.
The inspection occurred offsite on the following date(s): December 17, 24, 2025.

The following Critical Incident (CI) intakes were inspected:
-Intake: #00157067 -DOFU #: 1, Order type: CO under s. 155 (1) (a), issued on September 4, 2025 - related to skin and wound prevention and management, CDD with extension: November 15, 2025.
-Intake: #00159545 -CI 3067-000068-25 - related to falls prevention and management.
-Intake: #00160628 - CI 3067-000069-25 - related to infection prevention and control.
-Intake: #00161675 -CI 3067-000073-25 - related to resident care and support services.
-Intake: #00163761 -CI 3067-000085-25 - related to prevention of abuse and neglect.

The following complaint intakes were inspected:
-Intake: #00162540 - related to resident care and support services.
-Intake: #00163522 - related to prevention of abuse and neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Director Order #001 related to O. Reg. 246/22, s. 55 (2) (b)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Explanation of plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (12)
Plan of care
s. 6 (12) 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 explanation of the plan of care.

A resident returned from hospital with a new order. Staff did not communicate to the resident's substitute decision maker (SDM) of the change on readmission.

Sources: Communication with Family Members Policy, resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Licensee Must Comply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee did not comply with Directors Order (DO) #001 from inspection #2025-1708-0003 served on September 4, 2025, with extended compliance due date of November 15, 2025.

The following components were not complied:
3) Ensure that if changes were made to the skin and wound care program as a result of the review, staff who are involved with and deliver the skin and wound care program are educated on these changes and keep a record of who receives the education and the date(s) it was received.

As a result of the order changes were made to the Skin and Wound Program and staff were required to be educated on those changes. Education records provided at the onset of the Follow-Up Inspection (FUI) were incomplete. Records were unable to be verified as true copies, contained duplicate copies, and unclear dates. It was determined that records provided were insufficient to determine compliance and not all staff involved in the provision and delivery of the Skin and Wound Program received training by the compliance due date.

Sources: Directors Order #001 from inspection #2025-1708-0003, the home's follow up documentation, interviews with staff.

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #002

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 an order under s. 155 of the Act.

Compliance History:
N/A

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.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

During meal service, multiple residents on were observed receiving assistance with hand hygiene using cleaner and surface disinfectant wipes, which was not in accordance with the manufacturer's directions.

Sources: Observations and review of Pre-Empt Wipes One-Step Surface Cleaner and Disinfectant Label.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 1.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to themself, including any risk of falling, and interventions to mitigate those risks.

A resident's 24-hour admission care plan did not include the resident's falls risk and interventions to mitigate those risks.

Sources: Resident's clinical records, Falls Risk Assessment Policy, and an interview with staff.

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented.

A) A resident did not have falls risk assessments completed for two falls as per the home's falls prevention and management program.

Sources: Resident's clinical records, Falls Risk Assessment Policy, and an interview with staff.

B) A resident did not have a falls risk assessment completed for a fall as per the home's falls prevention and management program.

Sources: Resident's clinical records, Falls Risk Assessment Policy, and an interview 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).

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023), section 3.1 (h), staff were to ensure that the interdisciplinary IPAC team was regularly updated on surveillance findings.

A resident presented with symptoms and required isolation, the IPAC Lead was not notified.

Sources: resident's clinical records, Tracking and Reporting Resident Infections, and interview with IPAC lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

A) Resident presented with symptoms and required isolation. A review of their clinical records indicated that their symptoms and actions taken to reduce transmission were not recorded on every shift.

Sources: Resident's clinical records and an interview with IPAC lead.

B) Resident presented with symptoms and required isolation. A review of their clinical records indicated that their symptoms and actions taken to reduce transmission were not recorded on every shift.

Sources: Resident's clinical records, Surveillance Program, and an interview with IPAC lead.

WRITTEN NOTIFICATION: Emergency plans

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 3.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
3. Resources, supplies, personal protective equipment and equipment vital for the emergency response being set aside and readily available at the home including, without being limited to, hand hygiene products and cleaning supplies, as well as a process to ensure that the required resources, supplies, personal protective equipment and equipment have not expired.

A medical emergency occurred on the main floor, supplies were not readily available on the main floor during this time including various medical equipment.

Sources: Video footage, Code Blue Policy, Code Blue Emergency Debrief Form, and interviews with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 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:
1.Develop a case study of this incident of neglect and review, in person, with all

registered staff in the home and all Personal Support Workers (PSW) that work on a specified floor.
2.The case study should reflect the home's current policies and include, but not limited to: correctly identifying wounds, the location of the wound being evaluated is clear, residents at high risk of skin impairment have a specified equipment in place, all skin integrity issues are evaluated and have weekly wound assessments, all treatment orders specify the wound and location clearly, all residents at high risk of skin impairment, especially bed/chair bound residents, are turned and positioned every two hours and ensure documentation in Point of Care (POC).
3.Maintain a written record of the case study, including who participated, the name of the person presenting the case study and the date(s) the case study was presented.
4.Audit residents with identified pressure injuries in the whole home for one month, to ensure compliance with the Skin and Wound Care Program related to pressure injuries.

Grounds

A) The licensee did not protect a resident from neglect by staff related to skin and wound prevention and management.

O. Reg. 246/22, section seven defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On admission, a resident was assessed as an identified risk level for skin impairment and had no pressure injuries at that time. Although, skin concerns were identified on admission, Skin and Wound Evaluations and weekly assessments were not completed as required. Consistent shift-to-shift skin observations were not completed, the resident was not added to the bath list on admission and did not receive a bath for a period of time. Preventative measures, including appropriate equipment and a turning and positioning schedule, were not implemented as required.

Over multiple instances, new and ongoing skin concerns were identified by personal support workers (PSW), registered staff, and external clinicians; however, appropriate follow-up did not occur. In some cases, skin issues identified by PSWs were not reported to registered staff. Required assessments, including Skin and Wound Evaluations and Pressure Ulcer Risk Assessment (PURS) assessments, were

repeatedly missed. Documentation inconsistencies, such as incorrect anatomical descriptions and missing wound locations, further contributed to gaps in care.

Treatment orders were initiated without supporting clinical assessments or documentation. Several wounds identified by a wound care physician lacked corresponding assessments and the required weekly monitoring.

The cumulative failures to assess, monitor, document, communicate, and implement appropriate preventative and therapeutic interventions placed the resident at risk and represented a pattern of inaction. These gaps contributed to a significant decline in the resident's health status.

Sources: Interview with Coroner, Resident's clinical record, staff interview, email record, Partners Community Health (PCH) Pressure Injury and Wound Management Policy, PCH Preventative Skin Care Policy, PCH Skin Assessment Policy.

B) Section 2 of the Ontario Regulation (O. Reg.) 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

A resident pushed another resident, resulting in a skin tear.

Sources: Residents' clinical records, LTCH internal investigation notes, and interview with staff.

This order must be complied with by March 13, 2026

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 #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $22000.00, 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:

FLCTA 2024 s. 24 (1)

This is the fourth 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.

COMPLIANCE ORDER CO #002 Emergency plans

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
vi. medical emergencies,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.A Clinical Lead or designate create a detailed case study of a Code Blue scenario when a resident is choking; and
2.Ensure the case study reflects the home's current policies and includes the following but not limited to: Lead Nurse's role and responsibilities, determining code status and next steps, Emergency Record Flow Sheet (who fills this and when), equipment involved and when to clear a Code Blue; and

3.All registered staff: Registered Practical Nurse (RPN) and Registered Nurse (RN), Assistant Director of Care (ADOC) and Director of Care (DOC) are to participate in the case study in-person; and
4.Maintain a written record of the case-study, including but not limited to: the name and designation of the individual(s) creating the case study, the content of case study, the date(s) the case study was delivered in-person, the name(s) of the person presenting the case study, and name and designation of staff who participated.

Grounds

A) In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had medical emergency procedures in place and that it was complied with.

The home's Code Blue policy stated Do Not Resuscitate (DNR) order does not pre-emptive the application of Cardiopulmonary Resuscitation (CPR) in reversible conditions such as choking and CPR should be initiated until paramedics arrive. Staff did not follow their policy during a choking incident.

Sources: resident's clinical records, written statement by a staff, Code Blue Policy, Management of a Choking Hazard Policy, and interviews with staff.

B) A resident was having a medical emergency, staff did not complete the Emergency Record Flow Sheet which contained information such as when CPR was initiated, when EMS arrived, and time stamps of assessments and treatments completed.

When staff did not follow the medical emergency policies and procedures, life-saving measures were not implemented appropriately.

Sources: resident's clinical record, Code Blue Policy, Emergency Record Flow Sheet, and interviews with staff.

This order must be complied with by February 12, 2026

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.