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

Original Public Report

Report Issue Date: June 7, 2024
Inspection Number: 2024-1707-0004
Inspection Type: Complaint Critical Incident
Licensee: Partners Community Health
Long Term Care Home and City: Wellbrook Place East, Mississauga

Lead Inspector	**Inspector Digital Signature**
Daria Trzos (561)	Daria Trzos Digitally signed by Daria Trzos Date: 2024.06.11 14:15:02 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2, 3, 8, 9, 10, 13-17, 20-24, 2024.

The following intake(s) were inspected:

- Intake: #00105282 - Critical Incident (CI) - Fall with injury
- Intake: #00105688 - CI - Fall with injury
- Intake: #00108242 - CI - Fall with injury
- Intake: #00108428 - CI - Fall with injury
- Intake: #00109537 - Complaint with multiple care concerns
- Intake: #00110538 - CI - Fall with injury
- Intake: #00111771 - CI - Fall with injury

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 271 (1) (c) (ii)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(c) direct contact information, including a telephone number and email address that are monitored regularly for,
(ii) the Administrator,

The licensee has failed to ensure that that they had a telephone number for the

Administrator of the home included on their website.

Rationale and Summary
The home's website did not have the direct telephone number for the Administrator of the home which was acknowledged by the Director of Care (DOC).
The website was updated on May 10, 2024 with the information required.

Sources: Review of the home's website; interview with the DOC.
[561]

Date Remedy Implemented: May 10, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 271 (1) (c) (iii)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(c) direct contact information, including a telephone number and email address that are monitored regularly for,
(iii) the Director of Nursing and Personal Care,

The licensee has failed to ensure that that they had a a telephone number for the Director of Care of the home included on their website.

Rationale and Summary
The home's website did not have the direct telephone number for the DOC of the home which was acknowledged by the DOC.
The website was updated on May 10, 2024 with the information required.

Sources: Review of the home's website; interview with the DOC.
[561]

Date Remedy Implemented: May 10, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 271 (1) (c) (iv)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(c) direct contact information, including a telephone number and email address that are monitored regularly for,
(iv) all infection prevention and control leads for the home;

The licensee has failed to ensure that that they had a telephone number for the infection prevention and control lead for the home included on their website.

Rationale and Summary
The home's website did not have the direct telephone number for the infection prevention and control (IPAC) lead for the home which was acknowledged by the IPAC lead.
The website was updated on May 9, 2024 with the information required.

Sources: Review of the home's website; interview with the IPAC lead.
[561]

Date Remedy Implemented: May 9, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident.

Rationale and Summary
A resident had documented identified behaviours which was confirmed by personal support worker (PSW) and registered staff. The care plan and kardex, did not have the behaviour and interventions in place to ensure safety of other residents included in the written plan of care. The DOC acknowledged that the written plan of care for the resident did not set out the planned care related to the identified behaviour.

Sources: Review of resident's progress notes, care plan, kardex, and Minimum Data Set (MDS) assessments; interview with PSW and registered staff, and the DOC. [561]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #005 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 was provided to a resident as indicated in the plan of care.

Rationale and Summary
A resident indicated that an aspect of care was not provided to them on an identified day. The plan of care for the resident had clearly identified the specified care related item. It was confirmed by registered staff member that the care was not provided as per the plan of care.

Failing to provide care as per the plan of care may have increased the risk for a negative outcome to the resident.

Sources: Review of the resident's plan of care; interview with resident and registered staff.
[561]

B) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan in relation to the call bell.

Rationale and Summary
The plan of care for a resident and interviews with staff indicated that the call bell was to be within reach for the resident. On an identified date it was observed that the resident's call bell was not within reach and the resident required assistance.

Not being able to access the call bell may have increased the risk for staff not be able to assist the resident on time or in case of an emergency.

Sources: Observations of the provision of care; review of resident's plan of care; interview with resident, PSW staff and the DOC.
[561]

WRITTEN NOTIFICATION: Plan of Care: revision required

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that the plan of care for resident was revised when the resident's care needs changed related to an health condition.

Rationale and Summary
A resident had a documented change in condition and was assessed by a health care provider. Tests were ordered and they came back with a positive result for an infection. The written plan of care was reviewed and was not updated to include the risk for the infection, symptoms to monitor for or interventions related to the infection. Registered staff stated that the care plan should have been revised to include the risk for the infection, signs and symptoms and interventions. The DOC acknowledged that the plan of care was not revised when resident's care needs changed.

Sources: Review of resident's plan of care; interview with registered staff, and the DOC.
[561]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #007 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.

The licensee has failed to ensure that a resident's 24-hour admission care plan identified the risk for falling and interventions to mitigate those risks.

Rationale and Summary
A resident was assessed to be at moderate risk for falls on admission. The 24-hour admission care plan was reviewed and did not include the assessed risk for falls or did not include any interventions to mitigate the risk. The Associate Director of Care (ADOC) who is also the lead for the Falls Prevention Program acknowledged that the 24-hour care plan did not identify the fall risk for the resident on admission.

There was an increased risk to the resident when the home failed to include the fall risk assessment and interventions to mitigate the risk for the resident.

Sources: Review of resident's clinical records, home's policy "MORSE Falls Risk Assessment" (October 20, 2023); interview with ADOC #02/Falls Lead and the DOC. [561]

WRITTEN NOTIFICATION: Menu planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (e)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) includes a choice of other available entrées and side dishes at all three meals and a choice of other desserts at lunch and dinner, to meet residents' specific needs or food preferences;

The licensee has failed to ensure that the home's menu cycle included a choice of entrées at the lunch meal, that met a resident's specific needs for a health condition.

Rationale and Summary
A resident required a specific menu for a health condition. At a lunch meal the menu had two choices. The resident did not like one of the choices and they were not able to have the other choice due to a restriction related to the health condition. Only one entrée choice was available in the Meal Suite computerized program for the resident to choose from when staff were obtaining meal selections. An alternative entrée choice was not planned and available in the computer.

PSW staff stated that an alternative entrée choice, that was appropriate for the resident's restriction, was not prepared or available for the resident. The resident indicated that they did not like the one choice available to them that day; however,

they ate some of it as there was nothing else for them to eat. The Registered Dietitian identified the resident was at high nutrition risk with recent significant weight loss at the nutritional assessment in 2024.

When an appropriate alternative entrée choice was not planned, prepared, and available for the resident, consistent with their dietary restrictions and preferences, there was a risk for inadequate nutritional intake and weight loss.

Sources: Observation of lunch meal service; review of resident's plan of care, lunch menu, and Meal Suite system, review of the policy "Meal service in the dining room" (May 2024); interviews with resident, PSW staff, Food Production Manager and Director of Dietary.
[561]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #009 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).

The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control related to additional screening requirements.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes,

dated September 2023, section 11.6 states that the licensee shall post signage at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Rationale and Summary
Observation of the home identified that the home has not posted signage at entrance and throughout the home that listed signs and symptoms of infections for self monitoring as well as the steps needed to take if an infection was suspected or confirmed. The IPAC lead acknowledged that the home has not posted the required signage.

Sources: Observations; interview with the IPAC Lead.
[561]

WRITTEN NOTIFICATION: Report re: critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident,

The licensee has failed to include in the Critical Incident, the names of all staff

members who were present or responded to an incident of a fall that resulted in injury and transfer to hospital.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director related to a fall of a resident who sustained an injury and was sent to the hospital for further treatment. The CI did not include the names of all staff members who were present or responded to the fall.

Sources: Review of a CI, review of resident's clinical records; interview with DOC. [561]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
-re-educate all agency PSW staff and agency registered staff on the home's

Principles of Lifting and Transferring policy. The home shall keep the record of the material provided at the education and the list of staff that attended with their confirmation of attendance
-re-educate an identified PSW on the home's policy related to the safe use of mechanical lifts. The home shall keep a record of the education and the PSW's confirmation of attendance
-Director of Care or designate shall perform two audits per week on care provided by an identified PSW to different residents to ensure the residents are safely transferred using mechanical lifts. These audits must be documented, including the date, resident name, the staff member who completed the audit, and actions made based on audit results until this order is complied by the Ministry of Long-Term Care.

Grounds
A) The licensee has failed to ensure that staff used safe transferring devices or techniques when assisting a resident.

Rationale and Summary
A resident sustained a fall and PSW staff along with the registered staff lifted the resident off the floor manually. The home's policy "Principles of Lifting and Transferring" (dated October 5, 2023), indicated that manual lifting of a resident's total body weight without equipment support was only recommended in an emergency.

Failing to use safe transferring devices when assisting a resident off the floor may have increased the risk for an injury.

Sources: Review of resident's clinical records, review of the home's policy "Principles of Lifting and Transferring" (dated October 5, 2023); interview registered

staff, ADOC #02 and the DOC.
[561]

B) The licensee has failed to ensure that staff used safe transferring when assisting a resident during a transfer using a lift.

Rationale and Summary
A resident was transferred using a lift with one person assistance. The resident's plan of care indicated that they were to be transferred using a lift with two-person assistance. The home's policy "Mandatory lift and transfer procedures" (dated October 5, 2023), indicated that it was an expectation that minimum two staff participate in all resident lifts and transfers procedures for safety of the resident, and this was confirmed by the DOC.

Failing to provide a safe transfer may have increased the risk for the negative outcome to the resident.

Sources: Observations; review of resident's plan of care, home's policy "Mandatory lift and transfer procedures" (dated October 5, 2023); interview with PSW staff and the DOC.
[561]

This order must be complied with by August 30, 2024

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

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.