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: May 31, 2024

Inspection Number: 2024-1707-0001

Inspection Type:
Post-Occupancy

Licensee: Partners Community Health

Long Term Care Home and City: Wellbrook Place East, Mississauga

Lead Inspector	**Inspector Digital Signature**
Yuliya Fedotova (632)	

Additional Inspector(s)
Michelle Warrener (107)
Alison Brown (000841)
Emmy Hartmann (748)
Parminder Ghuman (706988)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 1, 4-8, 11-12, 18-19 and April 2-4, 9-11, 15-16, 18-19, 2024.

The following intake(s) was inspected in this Post-Occupancy Inspection:

- Intake: #00109814 was related to safe and secure home.

NOTE: This inspection was conducted concurrently with Complaint Inspection #2024-1707-0003 and a Non-Compliance Remedied (NCR) with O. Reg. 246/22, s. 12 (1) (1) was identified during both inspections, which will be issued in a Complaint Inspection Report.

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
Staffing, Training and Care Standards

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: FLTCA, 2021, s. 15 (1) (a).
The licensee of a long-term care home failed to ensure that there was, (a) an organized program of nutritional care and dietary services for the home to meet the daily nutrition needs of the residents.

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

Rational and Summary
During an interview, a resident expressed a concern about food being tasteless in the home.

During an inspection, it was observed that there was no pepper in a small glass containers in the condiments' basket, other than table salt, available in an identified home area's servery.

Condiments and Spice Baskets Policy stated that residents would be provided with a variety of condiments and spices to allow for individualized taste preferences and suggested condiments and spices should be used to enhance the flavour of the food served to residents.

During an inspection, the Food Service (FS) Supervisor confirmed that there were baskets with condiments in each servery available in-home area's serveries. The Director of Dietary Services stated that spice racks were to be stored in the servery and they were to be brought out during meal services to make them available for residents.

It was observed that during lunch, pepper and table salt in condiment containers were available on some dining tables as well as Ketchup. It was also observed that a specified seasoning was on the resident's dining table.

During an interview, the resident was satisfied with the condiments provided to them at a specified meal.

Sources: Observations; the Condiments and Spice Baskets Policy; interviews with a resident, the FS Supervisor and the Director of Dietary Services.
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Date Remedy Implemented: March 25, 2024.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2).

Non-compliance with: FLTCA, 2021, s. 85 (3) (c).

The licensee of a long-term care home failed to ensure that the required information, such as the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

Rational and Summary

During an inspection, it was observed that there was no policy on Promotion of Zero Tolerance to Abuse noted on the Mandatory Postings board located in the main lobby in East Tower.

The Executive Director (ED) confirmed that the Zero Tolerance of Abuse and Neglect of Residents Policy was posted on mandatory posting board but from time-to-time people might remove it.

Later during an inspection, it was observed that there was the Promotion of Zero Tolerance to Abuse policy posted on the Mandatory Postings board located in the main lobby in East Tower.

Sources: Observations; interview with the ED.
[632]

Date Remedy Implemented: March 6, 2024.

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2).

Non-compliance with: O. Reg. 246/22, s. 264 (2) 3.

The licensee of a long-term care home failed to ensure that the package of information provided for in section 84 of the Act included information about the following: 3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 308 of this Regulation.

Rational and Summary

During an inspection, it was identified that the Partners Community Health (PCH) Admission package did not contain the following information: the obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 308 of this Regulation.

The Director of Care (DOC) and the Admission Co-ordinator stated that they could add missing information in writing to the Resident Consent Package.

On April 23, 2024, the Accommodation Agreement was revised and the following statement was added by the home: "…The resident is obligated to pay even when on medical leave, psychiatric leave, vacation or casual leave…".

Sources: PCH Resident Consent Package; interview with the DOC and the Admissions Co-Ordinator.
[632]

Date Remedy Implemented: April 23, 2024.

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2).
Non-compliance with: O. Reg. 246/22, s. 264 (2) 9.
The licensee of a long-term care home failed to ensure that the package of information provided for the purposes of clause 84 (2) (r) of the Act included information about the following: 9. The current version of the visitor policy made under section 267 of this Regulation.

Rational and Summary
During an inspection, it was identified that the Partners Community Health (PCH) Admission package did not contain the following information: the current version of the Visitor policy made under section 267 of this Regulation.

The DOC indicated that the most recent Visitor policy would be printed and included immediately to the package. The Admission Co-Ordinator stated that the Infection Prevention and Control (IPAC) policy and other information were verbalized to the residents and their families during the admission meetings.

Sources: PCH Resident Consent Package; interview with the DOC and the Admissions Co-Ordinator.
[632]

Date Remedy Implemented: April 9, 2024.

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (2)
The licensee of a long-term care home failed to ensure that there was a written policy that dealt with when doors leading to secure outside areas had to be

unlocked or locked to permit or restrict unsupervised access to those areas by residents.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee of a long-term care home was required to have, institute or otherwise put in place Building Safety – courtyards and balconies policy to ensure that the policy, (b) was complied with.

Rational and Summary
During an inspection, it was observed that a door, leading to a secured balcony, in a specified unit, was unlocked.

The home's "Building safety - courtyards and balconies" policy procedure stated that to ensure the safety of all residents, all doors leading to the secured balconies on all resident home areas, which were key locked, would remain locked and would only be operational between May 15 and October 15.

The ED confirmed that balconies' doors in residential areas were to be locked.

Sources: Observations; Building safety - courtyards and balconies" policy; interview with the ED.
[632]

WRITTEN NOTIFICATION: Plan of Care Based on Assessment of Resident

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2).
The licensee of a long-term care home failed to ensure that the care set out in the plan of care related to bathing was based on an assessment of a resident and on the

needs and preferences of that resident.

Rational and Summary
During an inspection, a resident stated that they had bed baths but not showers in the home and they did not have concerns with that. The resident responded positively if they would like to have showers.

The resident's care plan indicated that they preferred showers and required a specified assistance with bathing. The Bathing Schedule for a specified home area had the resident's bath scheduled on specified days.

The resident's plan of care reviewed for a specified period of time in March 2024, did not contain any documentation related to the resident's assessments on having a bed bath instead of a shower.

During an inspection, Staff #025 confirmed that the resident did not have showers, since their admission. Staff #036 stated that the resident was asked about their preferences and both showers and bed baths were provided, on some days the resident refused having a shower.

The DOC indicated that the resident's health status changed, since admission, that was why they did not get showers but received bed baths, despite they were assessed for showers.

Sources: Care plan, progress notes, the Bathing Schedule, the Documentation Survey Report; interviews with a resident and staff.
[632]

WRITTEN NOTIFICATION: Plan of Care Duty of Licensee to Comply with Plan

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7).

The licensee of a long-term care home failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rational and Summary

Bathing schedule for a specified home area had a resident's bath scheduled on specified days each week. The resident's care plan indicated their preferences for showers and specified assistance with bathing.

The Staffing schedule indicated that on a day in March 2024, four PSW staff members were working in a specified home area during evening shift, which was confirmed by the Staffing Clerk that it was according to the evening shift schedule.

The Documentation Survey Report completed by the PSW indicated "Not applicable" record on a day in March 2024, for the resident. Staff #034 indicated that wording "Not applicable" meant that the shower was not done.

During an inspection, the DOC stated that bathing, in a form of shower or bathtub, was to be provided to residents twice a week, unless there were physical limitations for a resident.

Sources: Care plan, Documentation Survey Report, Bathing and Staffing schedules; interview with a resident and staff.
[632]

WRITTEN NOTIFICATION: General Requirements

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2).

The licensee of a long-term care home failed to ensure that any actions related to bathing taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented.

Rational and Summary
During an inspection, a resident stated that they had bed baths but not showers in the home and they did not have concerns with that. The resident responded positively, when they were asked if they would like to have showers.

The resident's care plan indicated that they preferred showers and required a specified assistance with bathing.

The Bathing Schedule for a specified home area had the resident's bath scheduled on specified days each week.

Staff #036 indicated that the resident was usually asked about their preferences, by providing both options for them according to the Bathing Schedule, based on the resident's wishes.

The DOC indicated that the resident's health status changed since admission and that was why they did not get showers but were getting bed baths, despite they were assessed for showers.

The Daily Report Book for Residential Facilities for a specified home area and the

resident's progress notes did not contain documentation about bathing provided for the resident.

Sources: The care plan and progress notes, the Bathing Schedule, the Documentation Survey Report, the Daily Report Book for Residential Facilities, The Guidelines for Documentation for PSW Documentation Records; interviews with a resident and staff.
[632]

WRITTEN NOTIFICATION: Emergency Plans

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. iii.
The licensee of a long-term care home failed to ensure that the emergency plans provided for the following: 1. Dealing with emergencies, including, without being limited to, iii. community disasters.

Rational and Summary
The Emergency Management Policy and Procedures did not contain information on dealing with emergencies, including, community disasters.

The ED indicted that the home was currently working on these policies.

Sources: The Emergency Management Policy and Procedures; interview with the ED.
[632]

WRITTEN NOTIFICATION: Emergency Plans

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. x.

The licensee of a long-term care home failed to ensure that the emergency plans provided for the following: 1. Dealing with emergencies, including, without being limited to, x. gas leaks.

Rational and Summary
The Emergency Management Policy and Procedures did not contain information on dealing with emergencies, including, gas leaks.

The ED indicted that the home was currently working on these policies.

Sources: The Emergency Management Policy and Procedures; interview with the ED.
[632]

WRITTEN NOTIFICATION: Emergency Plans

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. xii.
The licensee of a long-term care home failed to ensure that the emergency plans provided for the following: 1. Dealing with emergencies, including, without being limited to, xii. boil water advisories.

Rational and Summary
The Emergency Management Policy and Procedures did not contain information on dealing with emergencies, including, boil water advisories.

The ED indicted that the home was currently working on these policies.

Sources: The Emergency Management Policy and Procedures; interview with the ED.
[632]

WRITTEN NOTIFICATION: Website

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 271 (1) (f).

The licensee of a long-term care home failed to ensure that the home's a website that was open to the public and included at a minimum, (f) the current version of the emergency plans for the home as provided for in section 268.

Rational and Summary

During an inspection it was noted that Wellbrook Place Operational - Partners Community Health's website did not contain the current version of the emergency plans, which was confirmed by the ED.

Sources: The home's website: Wellbrook Place Operational - Partners Community Health website; interview with the ED.
[632]

COMPLIANCE ORDER CO #001: Doors in a home

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

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

The licensee shall:

- Have all doors leading to non-residential areas in all resident home areas locked.
- Develop and implement a policy on doors security leading to non-residential areas in all resident home areas.
- Implement ongoing audit system at a frequency identified by the home on all doors being locked leading to non-residential areas in all resident home areas.
- Document audit results, including doors have been audited, corrective actions taken, if applicable, and names of staff conducted the audit.
- Educate staff working in all resident home areas on keeping all doors leading to non-residential areas locked.
- Document staff education, including names of staff members participated and dates.

Grounds

The licensee of a long-term care home failed to ensure that all doors leading to non-residential areas had to be equipped with locks to restrict unsupervised access to those areas by residents, and those doors had to be kept closed and locked when they were not being supervised by staff.

Rational and Summary

During an inspection in March 2024, it was observed the doors leading to non-residential areas, such as some soiled utility rooms, clean utility rooms, staff washroom doors, resident spa rooms in specified home areas and some doors in specified dining rooms leading to serveries were unlocked.

During an inspection, multiple staff indicated that these doors were to be locked.

The Executive Director, stated that doors leading to non-resident areas were to be locked.

Sources: Observations; interviews with staff.

[632]

This order must be complied with by July 11, 2024.

COMPLIANCE ORDER CO #002: Maintenance services

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)

The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

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

The licensee shall:

- Keep a Door Controller and alarm in good repair.
- Implement ongoing audit system at a frequency identified by the home on Door Controller and alarm functionality.
- Document audit results, corrective actions taken, if applicable, and names of staff members conducted the audit.

- Educate staff responsible for Door Controller and alarm functionality service.
- Document staff education, including names of staff members participated and dates.

Grounds

The licensee of a long-term care home failed to ensure that, procedures were developed and implemented to ensure that, (a) electrical equipment, such as wander guard alarm, was kept in good repair.

Rational and Summary

During an inspection, it was observed that there was no alarm sound at the main entrance in the home, when Associate Director of Care (ADOC) #1 was holding a wander guard.

ADOC #1 confirmed that there was no alarm (beeping) going off at the time of observation and a resident with a wander guard could leave the building, while sliding doors were open.

On another day during an inspection, it was observed that there was no alarm sound at the main entrance, when the Facilities Operations and Support Services Manager (FOSSM), who had a wander guard on hand, approached sliding doors.

Wander Guard Blue Wander Management Solution Policy indicated that Door Controller monitored the facility doors and when a Tag entered this field, the Tag was identified and an alarm was issued and the door can be automatically locked. If the door was open and the Tag was in proximity to the door, the system generated an alarm.

The FOSSM stated that they were still in the process of waiting ordered tablet to come to activate sliding door wander guard alarm.

Sources: Observations; Wander Guard Blue Wander Management Solution Policy; interviews with ADOC #1 and the FOSSM.

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This order must be complied with by July 11, 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.