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
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Public Report

Report Issue Date: January 15, 2025

Inspection Number: 2025-1707-0001

Inspection Type:
Critical Incident
Follow up

Licensee: Partners Community Health

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7, 8, 9, 10, 13, 14, and 15, 2025

The following intake(s) were inspected:

- Intake: #00118186 - Follow-up to Compliance Order (CO) #001 from inspection #2024-1707-0004 related to transfer and positioning.
- Intake: #00125332 - Follow-up to CO High Priority (HP) #003 from inspection #2024-1707-0005 related to responsive behavior.
- Intake: #00125333 - Follow-up to CO #009 from inspection #2024-1707-0005 related to skin and wound care.
- Intake: #00125334 - Follow-up to CO #007 from inspection #2024-1707-0005 related to plan of care.
- Intake: #00125335 - Follow-up to CO #006 from inspection #2024-1707-0005 related to plan of care.
- Intake: #00125336 - Follow-up to CO #005 from inspection #2024-1707-0005 related to plan of care.
- Intake: #00125337 - Follow-up to CO#004 from inspection #2024-1707-0005 related to plan of care.

- Intake: #00125338 - Follow-up to CO#010 from inspection #2024-1707-0005 related to dealing with complaints.
- Intake: #00125339 - Follow-up to CO(HP) #002 from inspection #2024-1707-0005 related to duty to protect.
- Intake: #00125340 - Follow-up to CO(HP) #001 from inspection #2024-1707-0005 related to plan of care.
- Intake: #00125341 - Follow-up to CO#008 from inspection #2024-1707-0005 related to complaints procedure - licensee.
- Intake: #00126228 - Critical Incident (CI): 3066-000051-24 related to prevention of abuse and neglect of a resident.
- Intake: #00126353 - CI: 3066-000049-24 related to prevention of abuse and neglect of a resident.
- Intake: #00127949 - CI: 3066-000058-24 related to prevention of abuse and neglect of a resident.
- Intake: #00130361 - CI: 3066-000062-24 related to infection prevention and control.
- Intake: #00132621 - CI: 3066-000067-24 related to prevention of abuse and neglect of a resident.
- Intake: #00132912 - CI: 3066-000068-24 related to falls prevention and management.
- Intake: #00133898 - CI: 3066-000071-24 related to prevention of abuse and neglect of a resident.
- Intake: #00135151 - CI: 3066-000073-24 related to falls prevention and management program.
- Intake: #00135254 - CI: 3066-000074-24 related to prevention of abuse and neglect of a resident.

The following intake(s) were completed in this inspection:

- Intake: #00122294 - CI 3066-000033-24 related to falls prevention and management program.
- Intake: #00122517 - CI: 3066-000036-24 related to falls prevention and management program.

- Intake: #00124037 - CI: 3066-000041-24 related to falls prevention and management program.
- Intake: #00126235 - CI: 3066-000050-24 related to falls prevention and management program.
- Intake: #00131908 - CI: 3066-000065-24 related to falls prevention and management program.
- Intake: #00132410 - CI: 3066-000066-24 related to falls prevention and management program.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1707-0004 related to O. Reg. 246/22, s. 40

Order #001 from Inspection #2024-1707-0005 related to FLTCA, 2021, s. 6 (7)

Order #002 from Inspection #2024-1707-0005 related to FLTCA, 2021, s. 24 (1)

Order #003 from Inspection #2024-1707-0005 related to O. Reg. 246/22, s. 58 (4) (b)

Order #004 from Inspection #2024-1707-0005 related to FLTCA, 2021, s. 6 (1) (a)

Order #005 from Inspection #2024-1707-0005 related to FLTCA, 2021, s. 6 (1) (c)

Order #006 from Inspection #2024-1707-0005 related to FLTCA, 2021, s. 6 (5)

Order #007 from Inspection #2024-1707-0005 related to FLTCA, 2021, s. 6 (10) (b)

Order #008 from Inspection #2024-1707-0005 related to FLTCA, 2021, s. 26 (1)

Order #009 from Inspection #2024-1707-0005 related to O. Reg. 246/22, s. 55 (2) (b) (iv)

Order #010 from Inspection #2024-1707-0005 related to O. Reg. 246/22, s. 108 (1) 1.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

A) The licensee has failed to ensure that a resident was protected from verbal abuse by another resident.

Ontario Regulations (O. Reg.) 246/22 s. 2 (1) (b) defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences".

On a specified date, a resident received verbal abuse from another resident which resulted in them fearing for their safety.

Sources: Critical Incident (CI) Report, resident progress notes and interviews with the resident, Director of Care (DOC), and an Assistant Director of Care (ADOC).

B) The licensee has failed to ensure that a resident was protected from physical abuse from another resident.

O. Reg. 246/22 s. 2 (1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On a specified date, another resident who exhibited responsive behaviours wandered into the resident's room and physically injured them. Staff were able to intervene and separated the residents.

Sources: Interviews with DOC, resident's clinical records and CI.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a staff used safe transferring techniques when assisting a resident. The home's Mandatory Lift and Transfer Procedures required a minimum of two staff to participate in all resident lifts and transfers without exception. On a specified date, a staff performed a one-person transfer with a mechanical lift for the resident. The staff acknowledged that they were aware of the requirements to transfer the resident with two staff members. An ADOC acknowledged the resident was transferred unsafely.

Sources: Resident's clinical records, CI, investigative notes, the home's Mandatory Lift and Transfer Procedures, and interviews with staff and an ADOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 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, and

The licensee has failed to ensure that when the licensee was required to notify the Director of an incident, they included the name of the staff members who were present or discovered the incident. On a specified date, the home submitted a CI report for a resident for an alleged physical abuse but did not include the name of the staff involved. The DOC acknowledged that they overlooked to update the name of the person involved in the incident.

Sources: Review of CI report and interview with DOC.

WRITTEN NOTIFICATION: Medication Management System

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to comply with the home's medication management system when a medication incident report was not completed prior to a registered staff completing their shift.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols developed for the medication management system were complied with.

Specifically, the home's Medisystem policy indicated that when a medication incident is discovered, staff are to document a medication incident report prior to finishing their shift.

Sources: Interview with an ADOC, the home's Medisystem policies and procedures, resident's clinical record.