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

Public Report

Report Issue Date: April 23, 2025

Inspection Number: 2025-1707-0004

Inspection Type:
Critical Incident

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): April 11, 14, 15, 17 & 23, 2025

The following intake(s) were inspected:

- Intake: #00136780 - Critical Incident (CI) related to prevention of abuse and neglect.
- Intake: #00136948 - CI related to prevention of abuse and neglect.
- Intake: #00140640 - CI related to falls prevention and management.

The following intakes were completed:

- Intake: #00136237 - CI related to falls prevention and management.
- Intake: #00139172 - CI related to falls prevention and management.
- Intake: #00140104 - CI related to falls prevention and management.

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

Prevention of Abuse and Neglect
Responsive Behaviours
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.

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

O. Reg. 246/22 s. 2 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

An incident occurred where one resident engaged in inappropriate physical contact with another resident who was unable to give consent related to significant cognitive impairment.

Sources: Interview with management, resident's clinical records and CI.

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