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: September 12, 2025
Inspection Number: 2025-1707-0007
Inspection Type: Complaint 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 dates: September 8-12, 2025

The following intakes were inspected:
- Intake: #00150898 - Critical Incident (CI) #3066-000046-25 - Resident Care and Support Services
- Intake: #00151503 - Complaint - Responsive Behaviors

The following intakes were completed:
- Intake: #00151042 - CI #3066-000048-25 - Fall Prevention
- Intake: #00151460 - CI #3066-000050-25 - Prevention of Abuse and Neglect

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

Resident Care and Support Services
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee has failed to ensure that a resident's rights to freedom of neglect were fully respected.

On a date in 2025, staff attempted to transfer a resident using a mechanical device. The resident was left on the device with an inappropriate attachment for an unsupervised period time. Neither of the two staff responded to the resident's care needs when the resident was calling out for help. The resident was not released from the device until a member of the management team intervened.

Sources: Critical Incident Report, staff and resident interviews.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report to the Director the allegation of improper treatment or incompetent care of a resident upon becoming aware of the use of inappropriate transferring devices, which resulted in resident injury.

Sources: Critical Incident Report, and resident interview.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure the suspected resident to resident abuse, which resulted in risk of harm to the resident was reported to the Director immediately.

Sources: interviews with staff, resident's clinical records, the LTCH's "reporting incidents of abuse policy", last revised January 6, 2025.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 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 staff used safe transferring devices when transferring a resident.

On a date in 2025, a resident sustained an injury when staff did not apply the correct transferring device attachment, which did not secure the resident appropriately.

Sources: Critical Incident Report, the home's internal investigation notes, progress notes, care plan and interview.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information

provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

The licensee has failed to identify factors that could potentially trigger altercations and potentially harmful interactions between two residents after the incident that occurred on a date in 2025. Two altercations occurred among both residents.

Sources: interviews with staff, residents' clinical records, Critical Incident Report, LTCHs investigation records.