

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Ottawa District**

347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

## Public Report

**Report Issue Date:** October 23, 2025

**Inspection Number:** 2025-1132-0003

**Inspection Type:**

Critical Incident

**Licensee:** Crown Ridge Health Care Services Inc.

**Long Term Care Home and City:** Westgate Lodge Nursing Home, Belleville

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 20 - 23, 2025

The following intake(s) were inspected:

- Intake: #00155854 - CI #2623-000008-25- Fall of a resident with injury
- Intake: #00157776 - CI #2623-000009-25 - Alleged improper/ incompetent care of a resident
- Intake: #00159572 - CI #2623-000011-25 - Fall of a resident with injury

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

- Prevention of Abuse and Neglect
- Falls Prevention and Management

## INSPECTION RESULTS

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## WRITTEN NOTIFICATION: Residents' Bill of Rights

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

**Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.**

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:

19. Every resident has the right to,

iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure confidentiality was maintained when two staff members emailed statements from their personal emails to the home regarding an incident of alleged neglect for a resident that occurred on a specified day in September 2025. In these emailed statements a specified resident identifier was used, which was noted to be a breach of confidentiality by the Director of Nursing.

**Sources:** Review of the Home's investigation file; and an interview with staff members

## WRITTEN NOTIFICATION: Duty to protect

NC #002 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.

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The licensee has failed to ensure that a resident was protected from neglect. On a specified day in September 2025, two staff members were found to have neglected a resident when they did not provide the required personal care. In an interview with staff members it was confirmed that neglect was founded through the Home's investigation.

**Sources:** Review of the Home's investigation file; and an interview with staff members