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: February 20, 2025

Inspection Number: 2025-1708-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Partners Community Health

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 3, 5, 6-7, 10-12, 14 & 18, 2025.
The inspection occurred offsite on the following date(s): February 13, 2025.

The following intake(s) were inspected:

- Intake: #00130954, CIS #3067-000093-24- Related to prevention of abuse and neglect.
- Intake: #00131558, CIS #3067-000094-24- Related to prevention of abuse and neglect.
- Intake: #00133472 - CIS #3067-000099-24 -Related to prevention of abuse and neglect.
- Intake: #00131635, CIS #3067-000095-24 -Related to Falls Prevention and Management.
- Intake: #00132743, CIS #3067-000097- Related to Infection Prevention and Control.
- Intake: #00133036 - Follow-up to CO #001 from inspection # 2024-1708-0004 related to certification of nurses.
- Intake: #00132836- Complainant with concerns regarding prevention of abuse and neglect, resident care and support services, falls prevention and management, pain management, continence care and bowel management, medication management and skin and wound care.
- Intake: #00133256 - Complainant with concerns regarding resident care and support services, menu planning, skin and wound care, staffing, training and care standards, falls prevention and management, continence care and bowel management, infection prevention and control program, personal care and support services.
- Intake: #00134343 -Complainant with concerns regarding plan of care and food nutrition and hydration.

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

- Intake: #00134671, CIS #3067-000104-24 - Related to Falls Prevention and Management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1708-0004 related to O. Reg. 246/22, s. 51

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication 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: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

A) The licensee has failed to ensure that resident's plan of care was reviewed and revised to reflect the resident's current level of assistance required for bed mobility and toilet use as per the Resident Assessment Instrument Minimum Data Set (RAI-MDS) Section G assessment and Point of Care tasks which indicated that the resident requires one person extensive assistance for this care.

Sources: Resident's care plan, Point of Care tasks (January and February 2025), RAI-MDS Section G assessment, and interviews with staff.

B) The licensee has failed to ensure that resident's plan of care was reviewed and revised to include an intervention as part of falls prevention and management strategy on a specified date when this was not implemented as a falls prevention intervention.

Sources: Resident's care plan, progress notes, and interview with staff.

C) The licensee has failed to ensure that resident's plan of care was reviewed and revised when Registered Dietitian reassessed the resident and recommended a fluid consistency change on an identified date. Resident's plan of care continued to indicate they were to receive the previous ordered fluid diet.

Sources: Resident's clinical records, dining observations, interviews with staff.

D) The licensee has failed to ensure that a resident's plan of care, specific to bathing assistance, was reviewed and revised on an identified date.

Sources: The resident's clinical records, interviews with staff, observations.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint concerning the care of the resident was immediately forwarded to the Director on an identified date.

Sources: Review of an email containing concerns related to the care of the resident, progress notes; interview with staff.

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 has failed to ensure that alleged abuse of a resident by a Personal Support Worker (PSW) was immediately reported to the Director.
Review of investigative file identified that a PSW witnessed abuse of a resident by another PSW on an identified date. This was not reported to the home.

According to FLTCA, 2021 s. 154 (3), the licensee is vicariously liable for staff members who fail to comply with FLTCA, 2021 s. 28 (1).

Sources: Review of investigative file, home's policy "Zero Tolerance of Abuse and Neglect of Residents" (dated September 24, 2023); interview with staff.

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 a PSW used safe transferring device and techniques when assisting a resident with transfers and re-positioning on numerous occasions in 2024.

Sources: Review of investigative file, resident's plan of care; interview with the staff.

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury was complied with.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that the written policies developed for the falls prevention and management program were complied with. Specifically, the home's Post Fall Assessment policy indicated if any possibility of a head injury (for witnessed fall) and for all unwitnessed falls to check pupil reaction and initiate Head injury routine (HIR).

On an identified date, the resident had an unwitnessed fall with visible injury to their head and no initial HIR was conducted.

Sources: Resident's post fall assessment, the home's Post Fall Assessment policy dated October 20, 2023, and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

A) The licensee has failed to ensure that when the resident exhibited altered skin integrity from an unwitnessed fall, they were reassessed at least weekly after the initial assessment.

Sources: Resident's wound tracker software, the home's Wound Assessment and Documentation Policy dated October 17, 2023, and interviews with staff.

B) The licensee has failed to ensure that when the resident exhibited altered skin integrity, they were reassessed at least weekly after the initial assessment.

Sources: Resident's wound tracker software, the home's Wound Assessment and Documentation Policy dated October 17, 2023, and interviews with staff.

C) The licensee has failed to ensure that when the resident exhibited altered skin integrity, they were reassessed at least weekly.

Sources: Resident's skin and wound assessment, Wound tracker software, orders, care plan, PCH Wound Assessment and Documentation policy (NUR-24.2) (October 17, 2023), and interview with staff.

D) The licensee has failed to ensure that a resident exhibiting altered skin integrity received at least a weekly skin assessment.

A review of the weekly skin assessments indicated that the weekly skin assessments were not completed when they sustained an injury on an identified date.

Sources: Interviews with staff and resident's clinical record.

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure the resident had strategies implemented to respond to their responsive behaviors towards other residents.

Sources: Resident's clinical records, interview with staff, Critical Incident Report (CI) # 3067-000099-24.

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented.

The licensee has failed to ensure the Behavioral Supports Ontario-Dementia Observation System (BSO-DOS) data collection sheets were completed for the resident on several dates in the 2024 year.

Sources: Resident's BSO-DOS forms, resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Medication management system

NC #009 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 program when medication was left at resident's bedside.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the medication management program were complied with. Specifically, the home's medication policy indicated when medications were administered to the resident ensure that all oral medications have been swallowed and do not leave medications at bedside, which did not occur for the resident on an identified date.

Sources: MediSystem August 2024, resident's progress notes, and interview with staff.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents were provided falls prevention and management training in 2024.

Sources: Falls Prevention and Management Education 2024 records and interview with staff.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in behavior management.

Sources: Surge Course Completion: Dementia Behavior Management, interview with staff.

WRITTEN NOTIFICATION: Resident Records

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that the resident's records were kept up to date. On an identified date the resident's skin alteration was resolved, however the care plan was not revised to reflect this and the order to monitor and treat the wound continued to remain active. Registered nursing staff continued to document that the skin alteration was monitored and treated after the identified date in the Medication and Treatment Administration Record.

Sources: Resident's skin and wound assessment, Wound tracker software, orders, care plan, treatment and medication administration records, and interview with staff.

COMPLIANCE ORDER CO #001 Duty of licensee to comply with plan

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Review the plan of care for three specified residents with the direct care providers that provide care to these residents to ensure they are aware of the

contents of the plan of care. This review shall be conducted by a member of the management team.

2) Maintain the record of this review, names of direct care providers who completed the review and the dates review was completed.

3) A member within the management team or a designate (Registered Nurse) RN is to conduct daily audits that captures day and evening shifts (total of two audits for reach resident per day) during a seven day period, to ensure:

- the prescribed diet order is provided to the specified resident when food and/or beverage is provided;
- all falls interventions are implemented for the specified resident as specified in the plan;
- assistance with personal hygiene, transferring, toileting and bed mobility is provided to the specified resident as specified in the plan.

4) Maintain the record of the audits performed in a seven day period including the dates and times of the audits, name and title of the auditor(s), names and designation of the staff audited, results of audits, and actions taken.

5) All audits conducted must be readily available for inspector review.

Grounds

A) The licensee has failed to ensure that the care set out in the plan of care for the resident was provided as specified in the plan when staff continued to provide

previous ordered fluid diet to

the resident on an identified date, during breakfast and lunch meal periods after the resident's diet order was changed.

Failure to provide the ordered consistency fluids to the resident when the plan of care changed increased the risk of inadequate fluid intake.

Sources

: Review of diet order change in Point Click Care and Synergy; interviews with staff; observations.

B)

The licensee has failed to ensure that the fall interventions, set out in the plan of care was provided to the resident, specifically the resident's fall interventions when the resident used assistive devices, as specified in the plan.

Sources:

Review of resident's care plan and observation of the resident on an identified date.

C) The licensee has failed to ensure that the care set out in the plan of care related to activities of daily living (ADLs) was provided to a resident as specified in the plan. On several occasions in 2024, PSW provided assistance with ADLs without the assistance of another staff member. Failure to provide the two-person assistance led to pain endured by the resident during care.

Sources:

Review of investigative file, resident’s plan of care; interview with staff.

This order must be complied with by

April 30, 2025

COMPLIANCE ORDER CO #002 Duty to protect

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

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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 24 (1) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

The Licensee shall prepare, submit, and implement a plan to ensure two specified residents are not abused by anyone.

The plan shall include but is not limited to short-term and long-term actions the home will take to ensure residents are protected from abuse by anyone.

Please submit the written plan for achieving compliance for inspection #2025-1708-0001 to

LTC Homes Inspector, MLTC, by email to HamiltonDistrict.MLTC@ontario.ca by March 5, 2025.

Please ensure that the submitted written plan does not contain any Personal Information (PI)/Personal Health Information (PHI).

Grounds

A) The licensee has failed to ensure that the specified resident was protected from physical abuse by another specified 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 an identified date, the specified resident injured another resident, resulting in a physical injury to the resident.

Sources:

Interviews with staff, resident's clinical records and CI #3067-000094-24.

B) The licensee has failed to protect a resident from abuse by a PSW.

O. Reg. 246/22, s. 2 (1) defines “physical abuse” as the use of physical force by anyone other than a resident that causes physical injury or pain and "verbal abuse" as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A resident was abused by a PSW on several occasions in 2024 that caused resident pain.

Sources

:

Review of investigative file, CI #3067-000093-24; interview with staff.

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

This order must be complied with by

April 30, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior CO (HP) under FLTCA, 2021 s. 24 (1) was issued in Inspection #2024-1708-0003 on August 29, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

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nvoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.