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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 12, 2025
Original Report Issue Date: April 4, 2025
Inspection Number: 2025-1708-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Partners Community Health
Long Term Care Home and City: Wellbrook Place West, Mississauga

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #002 was rescinded after a Director Review. CO #001 is included in this report for reference; however, was not amended. Therefore, the served date remains April 4, 2025.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 17-21, 24-28, 31, and April 1-4, 2025.

The following intake(s) were inspected:

- Intake: #00134669, CIS #3067-000103-24, was related to prevention of abuse and neglect.
- Intake: #00136491, was a complaint related to resident care and support services.

- Intake: #00136762, CIS #3067-000010-25, was related to prevention of abuse and neglect.
- Intake: #00136788, was a complaint related to resident care and support services.
- Intake: #00136855, CIS #3067-000012-25, was related to falls prevention and management.

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

- Intake: #00139624, CIS #3067-000017-25, was related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident's plan of care was unclear when it contained instruction for the use of two different types of continence care products.

The resident's written plan of care was revised prior to the end of the inspection.

Sources: a resident's clinical record, interviews with staff, observations.

Date Remedy Implemented: March 26, 2025

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's power of attorney (POA), was given the opportunity to participate fully in the development and implementation of the resident's plan of care, related to the resident's diagnostic testing results, when there was a delay for a specified timeframe to discuss the results.

Sources: A resident's progress notes; interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure a resident's plan of care was followed when:

A) On an identified date, the resident was not repositioned, as per their plan of care.
B) On an identified date, the resident was not put to bed, as per their plan of care.
C) For a period of four days, the resident's safety checks were not completed as required.
D) For a period of three months, the resident's plan of care related to bathing was not followed.

Sources: Documentation of a resident's care; a resident's care plan, progress notes, and physician's orders; interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure the home's policy to promote zero tolerance of abuse and neglect was complied with, when staff did not take a resident to a safe and secure environment, when they were witnessed being abused. They also did not comply with the policy when they did not identify and make note of potential witnesses, and staff that were working that may have witnessed the incidents.

Sources: Home's Abuse Policy, Investigation Procedures, Complaint Form; interviews with staff.

WRITTEN NOTIFICATION: Late Reporting

NC #005 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.

A) The licensee has failed to immediately report to the Director a witnessed incident of abuse of a resident, when a critical incident (CI) report was completed a day late.

Sources: a CI report; a resident's progress notes; the home's documents related to the incident; interview with staff.

B) The licensee has failed to immediately report to the Director, when they became aware of allegation of neglect of a resident, and a CI report was not completed immediately.

Sources: a CI report; a resident's progress notes; interview with staff.

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
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:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

A) The licensee has failed to ensure that a resident was assessed for pain prior to administering pain medication.

In accordance with Ontario Regulations (O.Reg.) 246/22, s. 11 (1) (b), where the Act or this Regulation required the licensee of a long-term care home to have in place any program, the licensee was required to ensure that the program was complied with.

Specifically, staff did not comply with the licensee's process for administering pain medication, which required staff to conduct a full pain assessment using an appropriate tool when administering pro re nata (PRN) pain medication to a resident.

Sources: Pain management Policy, pain assessment, progress note, plan of care, eMAR, interview with staff.

B) The licensee has failed to ensure that a resident received a pain assessment when they were readmitted after a fall with an injury.

In accordance with Ontario Regulations (O.Reg.) 246/22, s. 11 (1) (b), where the Act or this Regulation required the licensee of a long-term care home to have in place any program, the licensee was required to ensure that the program was complied with.

Specifically, staff did not comply with the licensee's process which required staff to conduct a full pain assessment during readmission when the resident returned to the home with an injury.

Sources: Pain management Policy, pain assessment, progress note, plan of care, eMAR, interview with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a post-fall assessment was completed on a resident when they had an unwitnessed fall.

Sources: Falls Prevention and Management Policy, falls assessment, progress notes, plan of care, post fall assessments, eMAR; interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 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 a resident's altered skin integrity was reassessed at least weekly throughout a period of five months and a half.

Sources: A resident's clinical records; PCH Wound Assessment and Documentation Policy; interviews with staff.

B) The licensee has failed to ensure that a resident's altered skin integrity on two different locations, were reassessed at least weekly.

Sources: A resident's Skin and Wound Evaluation; interview with staff.

WRITTEN NOTIFICATION: Pain management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that a resident was monitored for the effectiveness of pain medication administered.

Sources: Pain Management Program Policy, pain assessment, progress note, plan of care, eMAR, interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to ensure that a resident's written approaches to care related to responsive behaviours, were co-ordinated on an interdisciplinary basis, when a resident was not reassessed by Behavioural Support of Ontario (BSO) Lead, when they received a referral for the resident on an identified date.

In accordance with O. Reg. 246/22, s. 58 (1) 1., the licensee was to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in

responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, were developed to meet the needs of a resident with responsive behaviours.

Sources: A resident's progress notes, assessments; the home's policy; interview with staff.

WRITTEN NOTIFICATION: Evaluation

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (a)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

The licensee has failed to ensure that an analysis of an incidence of physical and verbal abuse, was completed.

Sources: Home's documents related to the incidents; interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed no later than one business day after a resident had a fall with an injury which resulted in a significant change in the resident's health condition.

Source: Falls Prevention and Management Policy, falls assessment, progress note, plan of care, CI, interview with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #013 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that all residents in a specified Home Area are protected from abuse by visitors.

Specifically, the licensee shall:
1) Complete an audit for any incidents of abuse, to ensure that all staff who witness, suspect, and/or hear about abuse by visitors, take action to ensure the resident's safety, including following the home's policy to promote zero tolerance of abuse and neglect of residents. The audit must be documented and records kept, and must include who completed the audit, the dates completed, and actions

taken.
2) Provide education to all staff in the specified Home Area on how to respond when they witness, suspect, and/or hear about an act of abuse, including a focus on the first course of action to take.
3) Ensure that the education provided is in-person, and include case scenarios of different situations that could arise involving abuse of a resident by visitors. The education should include an opportunity for staff to discuss the situations or cases.
4) Ensure that attendees are evaluated on their learning, and if gaps in learning are identified, further education or training should be provided.
5) Ensure each of the steps within the order is documented, and records kept. The documentation must include, but is not limited to, all staff educated with signatures, all staff that provided the education, all dates the education was provided, a copy of the education materials including discussions of situations or cases; the evaluation of learning, and any further education or training provided, by whom, and when.

Grounds

The licensee has failed to ensure that a resident was protected from physical and verbal abuse on an identified date.

Ontario Regulation 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.

On an identified date, staff failed to protect a resident from physical and verbal abuse, when they witnessed the abuse taking place.

The resident sustained injuries, and had a change in their mood, after the incident.

Sources: A resident's progress notes; the home's Zero Tolerance of Abuse and Neglect of residents Policy; interviews with staff.

This order must be complied with by May 15, 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 #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, 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:

FLTCA 2021, s. 24 (1) was issued as a CO on February 20, 2025, (#2025_1708_0001).
FLTCA 2021, s. 24 (1) was issued as a WN on November 26, 2024 (#2024_1708_0004).

FLTCA 2021, s. 24 (1) was issued as a CO (HP) on August 29, 2024. (#2024_1708_0003).

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

Invoice 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.

(A1)
The following order(s) has been rescinded: CO #002

COMPLIANCE ORDER CO #002 Plan of care

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

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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

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.