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

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

Public Report

Report Issue Date: July 30, 2025
Inspection Number: 2025-1192-0006
Inspection Type: Complaint Critical Incident
Licensee: Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.
Long Term Care Home and City: Almonte Country Haven, Almonte

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22-24, 28-29, 2025

The following intake(s) were inspected:

- Intake: #00148768 - 2692-000022-25 - Fall of resident resulting in injury with a change in condition
- Intake: #00151600 - 2692-000025-25 - Fall of resident resulting in injury with a change in condition
- Intake: #00153426 - Complaint regarding wheelchair accessibility of unit doors and concern with Residents' Council.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils

Safe and Secure Home
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 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 that the care as set out in a resident's plan of care was implemented as specified in the plan. Specifically, a resident's call light was not within reach when the resident was in their room as observed during the inspection. The resident's care plan specifies that the resident's call light is to be within reach as a fall prevention measure.

Sources:
Observation of a resident in their room;
A resident's care plan.

WRITTEN NOTIFICATION: Initial plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 28 (1) (b)

Initial plan of care
s. 28 (1) Every licensee of a long-term care home shall ensure that,
(b) the initial plan of care is developed within 21 days of the admission.

The licensee has failed to ensure that a resident's plan of care was developed within 21 days of admission. The specified resident had been admitted to the home over 21 days at the time of inspection. Upon review of the resident's care plan, as available on the resident's electronic medical record, seven sections of the resident's care plan were found not be completed. A resident's plan of care must be based on an interdisciplinary assessment which includes all the listed components specified Ontario Regulation 246/22 s. 29 (3). During the inspection, the inspector reviewed the resident's care plan again and found the sections listed above had since been completed after identifying the issue with the home's management team.

Sources:
A resident's electronic medical record and care plan

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that staff complied with the home's fall prevention

and management program. According to Ontario Regulation 246/22 s. 11 (1) b., the home's fall prevention and management program must include the monitoring of residents and that the program must be complied with.

A resident sustained a fall with a documented head injury on a specified date. The resident was placed on the 72 hours head injury routine (HIR) monitoring as required by the home's falls prevention and management program. According to the resident's neurological vital signs post head injury form, the resident was supposed to be assessed at specific time intervals, but two of the assessment intervals specified on the form were found to have no documented assessment. Further, when the resident was supposed to have their final neurological vital signs assessed the documentation indicates the resident was sleeping and no assessment was performed. According to Policy OTP-FP-7.4 Resident Falls and Post Fall Assessment, the HIR will continue for 72 hours post fall at the intervals required and that if the resident is sleeping at the time an assessment is required the resident must be woken.

A registered nurse (RN), during their interview, stated that there must be documentation for each required assessment in the HIR. The Director of Care (DOC), during their interview, stated that each assessment must be documented and performed on the neurological vital signs post head injury form and that residents must be woken for the assessment if sleeping.

Sources:
A resident's medical record;
Policy OTP-FP-7.4 Resident Falls and Post Fall Assessment;
Interviews with an RN and the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by an authorized person upon any return of the resident from hospital. Specifically, the licensee failed to ensure that a resident received skin assessments after their return from hospital on two separate occasions.

Sources:
Review of a resident's electronic medical record with an RN and the DOC;
Interviews with an RN and the DOC.

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument. Specifically, on a specified date, two Registered Practical

Nurses (RPN) both documented during the day that as needed (PRN) pain management was ineffective for a resident. After further chart review of the resident's pain assessments, the two RPNs did not document a full pain assessment after determining that the initial pain administrations they gave were ineffective and the resident remained in pain. One of the specified RPNs confirmed to the inspector that they did not perform a pain assessment after their initial pain management interventions on the specified date. The home's policy OTP-PM-5.1 Pain Management Program states that a pain assessment is to be completed when pain remains regardless of interventions.

An RN and the DOC both stated in their interviews that a pain assessment must be documented in the resident's chart if initial pain management interventions are ineffective. Both confirmed no full pain assessment was documented for the resident on the specified date.

Sources:
Review of resident's medical record with an RPN;
Interviews with an RN and the DOC.

COMPLIANCE ORDER CO #001 Protection from certain restraining

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than

under the common law duty referred to in section 39.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Equip all doors for entry and exit to the Mississippi Lane, Kintail Lane, and Naismith Lane units, that lead to other areas of the home appropriate for residents to access, with powered mechanical opening devices for residents who are appropriate to leave the units independently, to use the doors to enter and leave the units without assistance. Specifically, powered mechanical opening devices must be installed on Mississippi Lane unit's main entrance and exit door and the door which provides access to the throughway to Naismith Lane and the elevators; Kintail Lane unit's main entrance door; and Naismith Lane unit's main entrance door.
B) A management team member must conduct a review of all home area entrance and exit doors that residents can use, or will use after the completion of construction at the home, to ensure they are accessible for all appropriate residents to use independently without assistance. If an area entrance and exit door not specified in section (A) is determined to be a door which provides access to resident appropriate home areas and grounds, the licensee shall ensure it is equipped with a powered mechanical opening device accessible to residents.
C) A written record must be kept of all requirements specified in sections (A) and (B) including quote(s) from licensed contractors, invoices or workorders as proof of installation by a certified installer which specifies the date of installation, any required inspections or certifications if applicable, and the home's review of all resident area entry and exit doors including the name(s) of the reviewer(s), the doors reviewed, and if any doors not specified in section (A) required the installation of a powered mechanical door opener.

Grounds

The licensee has failed to ensure that no resident of the home is restrained by the use of barriers from leaving any part of the home, including the grounds of the home, or entering parts of the home generally accessible to residents. Specifically, the licensee has failed to ensure that all resident unit entry and exit doors are accessible, for appropriate residents, to enter and leave the units independently.

A resident informed the inspector, who ambulates independently with a wheelchair, that they are unable to or have great difficulty entering and exiting their unit independently as the entry and exit doors are not equipped with any powered mechanical opening device. The resident stated they either have to rely on staff members or family members to open the door for them to leave or attempt to hold the door open, with great difficulty, if no one is around to assist them. The resident further stated they often feel trapped on the unit due to the barrier these unit entrance and exits present.

Another resident, who is independent in their wheelchair to go outside, informed the inspector that they rely on staff members to open the a unit's main door for them to enter and leave and cannot leave the unit without any assistance.

Another resident, who is independent in their wheelchair, stated that they see independent residents on their unit who rely on staff members to open the unit door for them and cannot leave independently.

The inspector observed the resident unit entry/exit doors on Mississippi Lane, Naismith Lane, and Kintail Lane units and found that all the unit entry and exit doors appropriate for residents were not equipped with any powered mechanical opening devices and would not be accessible for independent residents who have any kind of mobility restriction or disability.

The Executive Director (ED) in their interview confirmed that two of the residents interviewed are independent to leave the units and are provided either a key card or pass code to unlock the unit doors. The ED further stated that all units in the home have residents living on the units that are independent to leave the units at will. The ED stated that Mississippi Lane, Kintail Lane, and Naismith Lane unit entrance and exit doors are not equipped with any powered mechanical device for appropriate wheelchair bound residents to leave independently. In a separate interview, the ED stated that the second entry and exit door from Mississippi Lane that leads to a hallway area currently under construction, would eventually contain resident areas and would be how residents could access Naismith Lane and Kintail Lane units from Mississippi Lane and vice versa. The inspector observed this door and found it not to be equipped with a powered mechanical opener device for handicap access.

Sources:
Observations of entry and exit doors for resident areas on Mississippi Lane, Kintail Lane, and Naismith Lane units;
Interviews with three residents and the ED.

This order must be complied with by October 23, 2025

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.