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
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Public Report

Report Issue Date: September 26, 2025
Inspection Number: 2025-1192-0007
Inspection Type: 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): September 23-26, 2025.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00153852 / CI #2692-000031-25 and Intake: #00154176 / CI #2692-000032-25 - Related to physical abuse of a resident by staff.

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

Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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.

The licensee has failed to ensure that a resident was protected from physical abuse.

O. Reg. 246/22, section 2 (2) defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

In July 2025, a Personal Support Worker (PSW) witnessed an incident of potential physical abuse by a PSW to a resident while providing care. The PSW reported the incident the next day to the Director of Care (DOC). The DOC did not take immediate action, and the PSW continued to provide care to residents the day the incident was reported. Action was taken by the DOC two days after the incident occurred.

Sources: Resident's record review, the Critical Incident Report, Zero Tolerance of Abuse and Neglect of Residents Policy # OP-AM-6.9, and interviews with a PSW and the DOC.

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) 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 an incident of alleged staff to resident physical abuse was reported immediately to the Director in July 2025.

The Director of Care (DOC) was notified of the incident the next day, and the alleged staff to resident physical abuse incident was reported to the Director, two days after the incident occurred.

Sources: Resident's record review, the Critical Incident Report, and an interview with DOC.