

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: October 6, 2025

Inspection Number: 2025-1178-0009

Inspection Type:

Complaint
Critical Incident

Licensee: Omni Quality Living (Lambton) Limited Partnership by its general partner, Omni Quality Living (Lambton) GP Ltd.

Long Term Care Home and City: Bear Creek Terrace, Petrolia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23-26, 2025 and October 1-3 and 6, 2025

The following intake(s) were inspected:

- Intake: #00155569 - Unexpected death of resident.
- Intake: #00156119 - Resident to resident abuse.
- Intake: #00156438 - Complaint related to care of resident.
- Intake: #00158303 - Outbreak.
- Intake: #00158829 - Fall of resident resulting in injury.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours

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Prevention of Abuse and Neglect
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 failed to ensure that the intervention set out in the plan of care was provided to the resident.

A resident's care plan stated that the resident required an intervention, however, during inspection the resident did not have the intervention in place.

During an interview, Director of Care (DOC) confirmed that the resident did not have the intervention in place and should have been in place.

Sources: Resident clinical records; observations; interviews with DOC.

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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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.

The licensee has failed to ensure that the pain management program was complied when three residents did not have pain assessments completed as required.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure the written policies developed for the pain management program were complied with.

Specifically, following a resident-to-resident incident, three residents had orders on their Medication Administration Records (MAR) for pain assessments to be completed in PointClickCare (PCC) every shift for five days. Review of the residents' PCC assessments tabs showed that during the five-day period, two of the residents did not receive pain assessments during three shifts, and the other resident did not receive a pain assessment during two shifts despite registered staff signing them as complete on each resident's MAR. The Director of Care confirmed the assessments were not completed as required.

Sources: Clinical record review for the three residents; Policy OTP-PM-5.3 Pain Assessment; interview with DOC.

WRITTEN NOTIFICATION: Resident records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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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 a resident's written record was kept up to date at all times.

Review of a resident's clinical record showed that a resident was to be monitored using the Behavioural Supports Ontario - Dementia Observation System (BSO-DOS) data collection sheet and documentation was to be completed. Documentation showed that there were twenty-two time periods where the BSO-DOS documentation was blank. The Director of Care (DOC) stated the resident was monitored, but the documentation was not completed and should have been.

Sources: Resident clinical record review; interview with DOC.