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: May 30, 2025
Inspection Number: 2025-1289-0001
Inspection Type: Critical Incident
Licensee: Pleasant Manor Retirement Village
Long Term Care Home and City: Pleasant Manor Retirement Village, Virgil

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22, 23, 26-29, 2025

The following Critical Incident (CI) intake(s) were inspected:

Intake #00140545/CI #2799-000001-25 - related to falls prevention and management
Intake #00141807/CI #2799-000003-25 - related to resident care and support services
Intake #00147047/CI #2799-000004-25 - related to the prevention of abuse and neglect

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Falls Prevention and Management

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 verbal abuse by a staff member.

O. Reg 246/22 s. 2 (1) (a) defines 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.

An allegation of verbal abuse by a staff member towards a resident was substantiated through the home's investigation, and disciplinary action was taken against the involved staff member.

Sources: Home's internal investigation report, Critical Incident Report, and an interview with the Administrator.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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 staff member used a safe transferring and positioning device and techniques when assisting the resident.

A resident required total staff assistance using a specific device for transfers as per their plan of care. The home's internal investigation confirmed that a staff member transferred the resident independently without using the required device.

Sources: Incident Investigation Notes, Resident's Plan of Care, Home's Lifts and Transfer Policy (last reviewed in May 2025), interviews with staff and the Administrator.

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 (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 failed to ensure that the home's fall program was complied with, specifically, registered staff failed to complete the head injury routine assessments for the resident following unwitnessed fall incidents.

According to Ontario Regulations 246/22, s. 11 (1) (b), where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee is required to ensure that the program is complied with.

The home's policy titled "Falls Prevention and Management Program" stated that in the event of an unwitnessed resident fall incident, registered staff should complete a specific assessment. On specified dates, a resident had unwitnessed falls. The Administrator acknowledged that for the identified resident fall incidents, the registered staff did not complete the required assessments as mandated by the home's policy.

Sources: Interview with the Administrator, review of the home's policy titled "Fall Prevention and Management Program" – last revised in January 2024, and review of the resident's clinical records.

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