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

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Public Report

Report Issue Date: November 18, 2025

Inspection Number: 2025-1002-0006

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: Kentwood Park, Picton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24, 27-30, 2025 and November 3-7, 10, 12-14, 17, 2025.

The following intake(s) were inspected:
-Intake: #00158320 - CI #0893-000027-25; Intake: #00158784 - CI #0893-000029-25 - Alleged staff to resident abuse.
-Intake: #00158673 - CI #0893-000028-25 - Alleged resident to resident abuse.
-Intake: #00160252 - CI #0893-000033-25 - Medication incident for resident with adverse effect.
-Intake: #00160339 - CI #0893-000034-25 - Controlled substance missing/unaccounted.
-Intake: #00159872 - Complaint received with concerns regarding resident care.
-Intake: #00162097, Intake: #00162102, and Intake: #00162277 - Complaints received related to the discharge of a resident.

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

Skin and Wound Prevention and Management
Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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 set out in a specified resident's responsive behaviour plan of care was provided to the resident as specified in the plan.

On a specified day in September, 2025, a resident reported that the evening prior, a staff member was ignorant towards them and made negative comments. A registered staff member who overheard the incident, stated the resident was being verbally responsive to the accused staff member. The resident's responsive behaviour plan of care indicated strategies and interventions for verbal responsiveness, and those interventions and strategies were not applied.

Sources: Resident's written plan of care and progress notes in Point Click Care (PCC), the licensee's investigation notes, and interviews with staff and management.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the application of a treatment to a specified resident in the home, as set out in the plan of care, was documented. It was confirmed during interviews, that there was no identified area within the residents health care record to document the application of the treatment.

Sources: Resident's progress notes, TRC Skin Assessment (Admission), Care Plan, Personal Support Worker (PSW) Treatment Administration Record (TAR), Documentation Survey Report; Interviews with staff and residents.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24
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.

(2) The duties in subsection (1) do not apply where the resident is absent from the home, unless the resident continues to receive care or services from the licensee, staff or volunteers of the home.
(3) Every licensee who contravenes subsection (1) is guilty of an offence.

The licensee has failed to protect two specific residents from neglect.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified morning in October, 2025, it was discovered that a resident's medication from the evening prior was not administered, including medication for pain management. The resident experienced pain with care the following day. The registered staff member #115 responsible for the medication error returned to work the following day, and began medication pass, but was later sent home on administrative leave. The registered staff member who took over the responsibility of medication administration noted they could not complete two of the resident's medication passes, that were scheduled three hours after registered staff member #115 was sent home, as the medication was not available.

On a day in March, 2025 a second resident was prescribed treatment for an infected wound. A Pharmapod medication incident indicated there were three missed doses of the treatment, which was not reported until two days after the treatment ended. Two days after the incident was reported, it was noted the resident's wound was deteriorating, with complaints of pain and mobility changes later in the week. The resident was prescribed a second course of treatment 18 days after the initial treatment was prescribed.

It was confirmed during interviews with management, the registered staff member #115 had an extensive history of medication errors and omissions over the span of three months, that required extensive reinstruction. It was confirmed medication errors continued over the next five months after reinstruction occurred, with no corrective-actions issued until October, 2025, when registered staff member #115 was placed on administrative leave.

Sources: Progress notes for residents; Investigation folder; resident's PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD) on October, 2025, and Medication Administration Record (MAR) October 2025; Pharmapod safety report including medication incidents; resident's order audit reports; interviews with staff and management.

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 their written policy related to zero tolerance of abuse and neglect of residents was complied with for a specified resident.

On a day in September, 2025, a resident was allegedly verbally abused by a staff member. The staff member continued to work on this day. the Executive Director

(ED) was not made aware of this incident until the following day. The ED confirmed that within their policy, any allegations of staff to resident abuse require the staff member to be placed on administrative leave immediately pending the investigation.

Sources: Resident's progress notes in PCC, the licensee's investigation notes, the licensee's policy 'Zero Tolerance of Abuse and Neglect of Residents, #OP-AM-6.9, last reviewed May 7, 2025, and interviews with staff and management.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to a specific resident was immediately reported to the Director.

On a specific day in September, 2025, a PSW was allegedly verbally abusive towards a resident. This was not reported to the Director until the following day.

Sources: Resident's progress notes on PCC, the licensee's investigation notes, and interviews with staff and management.

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) 3.
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:
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The licensee has failed to comply with the licensee's Bowel and Bladder Continence Assessment and Care Planning Policy for a resident in the home. In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that their written policy related to continence care is complied with.

Specifically, the Bowel and Bladder Continence Assessment and Care Planning Policy indicated registered staff will ensure the voiding pattern for urine and stool output is documented on the paper voiding record or point of care electronic record for a minimum of 72 hours prior to the completion of a continence assessment.

The Resident was admitted on a specified day in August, 2025. It was confirmed that during the resident's admission, a paper voiding record was required. Management confirmed there was no paper voiding record completed for the resident.

Sources: Bowel and Bladder Continence Assessment and Care Planning Policy #OTP-ECC-1.5 (March, 2025); Lack of paper voiding record; Interview with management.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a specific resident, who was exhibiting altered skin integrity, received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Specifically, the resident was noted to have altered skin integrity on two occasions, with one area requiring treatment. There were no skin assessments noted within the residents records.

Sources: Resident's progress notes, Multidisciplinary Care Conference, Skin and Wound Assessments; Interviews with staff and management.

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to comply with the licensee's Supporting a Resident with Responsive Behaviours Policy, for a specified resident of the home. In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that their written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are complied with.

Specifically, the Supporting a Resident with Responsive Behaviours Policy (March, 2025) indicated a comprehensive behavioural assessment is to be completed for each resident at the time of admission. It was confirmed that this assessment was not completed for the resident following their admission on a specific day in August, 2025. Admission assessments completed on the resident did confirm a history of responsive behaviours.

In the previous (March, 2025) and current version (September, 2025) of the Supporting a Resident with Responsive Behaviours Policy, it was indicated that the Behavioural Supports Team Conversation Guide should be used to collect information during a huddle/conversation with clinical team members and partners to capture their experience and knowledge about the responsive behaviours/personal expressions {e.g. possible contributing factors, strategies/approaches that have been tried and their outcomes), their priority concerns, the associated risks, key personhood information and to start to build a collaborative action plan that will support the resident. During interviews with registered staff, it was confirmed staff were not familiar with this guide, or instructions and frequency of completion. Management confirmed this was not

completed for the resident.

In the current version (September, 2025) of the Supporting a Resident with Responsive Behaviours Policy, it indicated that when a new or escalated behaviour is identified, the clinical team shall initiate follow up assessments or observation tools as appropriate. The policy also specifies that the nursing care plan shall identify the resident's behavioral triggers and be reflective of the individualized supportive measures and Behavioural Supports Ontario (BSO) strategies that are. The resident's care plan did not identify triggers or strategies for known responsive behaviours. Staff and Management confirmed a Dementia Observation System (DOS) should have been completed for the resident, during onset of behaviours, and was not.

Sources: Supporting a Resident with Responsive Behaviours Policy # SM-1.6 (March, 2025 and September, 2025;, Resident's Ontario Health at Home admission behavioural assessment, progress notes, Violence Assessment Tool, Multidisciplinary Care Conference, Care Plan and 24-hour care plan, and Kardex; Interviews with staff and management.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.
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):
3. A missing or unaccounted for controlled substance.

The licensee has failed to ensure that two incidents of controlled substances that were unaccounted for in June, 2025, were reported to the Director within one business day after the occurrence of the incident.

Sources: Pharmapod medication incident events, absence of reports within the Critical Incident System, interview with staff.

WRITTEN NOTIFICATION: When licensee may discharge

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 157 (2) (b)
When licensee may discharge
s. 157 (2) For the purposes of subsection (1), the licensee shall be informed by,
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

The licensee has failed to ensure that they were informed by a specific resident's attending physician at the time of absence from the home that their requirements for care had changed and as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or persons who come into contact with the resident prior to the resident's discharge.

On a day in November, 2025, the resident left the Long-Term Care Home (LTCH). The following day, the licensee discharged the resident from the LTCH while still absent from the home. The licensee was not informed by the resident's attending physician prior to discharging the resident.

Sources: Resident's progress notes in PCC, the licensee's discharge letter to

resident, other progress notes for resident, and interviews with third party, and management.

COMPLIANCE ORDER CO #001 Administration of drugs

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1. Complete in person education with all staff responsible for administration of drugs, on safe medication administration practices.
2. Develop and implement a process for ensuring that medication passes are completed safely, and in compliance with the policy for completion of a medication pass.
3. Maintain a written record of the requirements under (1) and (2). Documentation of education shall include the names of the staff, their designation, the date training was provided, the name of who provided the training, and a copy of training materials and documents utilized.

Grounds

1. The licensee has failed to ensure that drugs were administered to residents #005, #006 and #007 in accordance with the directions for use specified by the

prescriber.

On a specified morning in October, 2025, it was discovered that resident #005's medication from the evening prior was not administered, including medication for pain management. Resident #005 experienced mild pain with care the day following the medication incident. The registered staff member #115, who was responsible for the medication incident, returned to work the following day, and began medication pass, but was later sent home on administrative leave. The registered staff member who took over the responsibility of medication administration, noted they could not complete two of the residents medication passes, that were scheduled three hours after registered staff member #115 was sent home, as the medication was not available. The Executive Director confirmed medication from three scheduled medication passes, had all been administered prior to registered staff member #115's departure.

Resident #006 was prescribed treatment for an infected wound. A Pharmapod medication incident indicated there were three missed doses of the treatment, which was not reported until two days after the treatment ended. Two days after the incident was reported, it was noted resident's wound was deteriorating, with complaints of pain and mobility changes later in the week. The resident was prescribed a second course of treatment on 18 days after the initial treatment was prescribed.

Resident #007 was prescribed pain medication, as required. On a day in June, 2025, resident #007 was administered double the maximum dose prescribed. Inspector could not locate assessments or progress notes to indicate if the resident was assessed following the medication error for adverse effects.

Sources: Progress notes for residents; Investigation folder for CI; resident #005's

PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD), and MAR October 2025; Pharmapod safety report including medication incidents; resident #006's order audit reports; resident #007's assessments and vitals; interviews with staff and management.

2. The licensee has failed to ensure that treatment prescribed to a specified resident on a day in September, 2025, for treatment of altered skin integrity, was administered in accordance with the directions for use specified by the prescriber.

Specifically, there were five missing entries from September 2025 to October, 2025, where the medication was not signed as administered. Additionally, there were four occurrences where the medication was documented as administered to locations other than where the treatment was prescribed to be applied.

Sources: Resident's progress notes, written prescribers orders, PSW TAR, and Medication Orders in PCC; Interviews with staff and management

This order must be complied with by January 2, 2026

COMPLIANCE ORDER CO #002 Plan of care

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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

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

Specifically, the licensee shall:

1. Develop and implement a process that includes how staff access and revise a resident's written plan of care. This process should also ensure that the information within the care plan is consistent and accurate with the Kardex.
2. Provide in person education to all direct care staff on the process identified in (1).
3.. Review and revise, as necessary, the written plan's of care for both residents within the grounds, to ensure they cover all aspects of care, are up to date and consistent, and provide clear directions to those who provide direct care.
4. Maintain a written record of the requirements under (1) (2) and (3). Documentation of education shall include the names of the staff, their designation, the date training was provided, the name of who provided the training, and a copy of training materials and documents utilized.

Grounds

1. The licensee has failed to ensure that there was a written plan of care for a specified resident that set out clear directions to staff and others who provide direct care to the resident.

Specifically, multiple areas of the written plan of care for the resident indicated conflicting and inconsistent directions in respect to toileting and continence. Multiple staff confirmed directions in practice also differ from the directions within the written plan of care.

Management confirmed the written plan of care for the resident is unclear and does

not provide clear direction to staff. Additionally management confirmed PSWs rely on the Kardex, and currently PSW staff do not know how to access the Kardex on Point Of Care (POC).

Sources: Resident's progress notes, current plan of care and Kardex; interviews with staff and management.

2. The licensee has failed to ensure that there was a written plan of care for a specified resident, that set out clear directions to staff and others who provide direct care to the resident.

In January 2025, interventions for responsive behaviours were initiated for the resident. In May 2025, the interventions were discontinued. The resident's plan of care indicates they are currently receiving the interventions that were discontinued. Staff members indicated that the resident is no longer utilizing these interventions.

On a day in September, 2025, the resident was involved in a verbal altercation with another resident. Staff indicated the resident has verbal responsive behaviours in relation to a known trigger. The resident's plan of care indicated they have behaviours surrounding the specified trigger, but did not identify on the resident plan's of care the type of responsive behaviours the resident has.

Sources: Resident's current plan of care and progress notes in PCC, BSO binder, and interviews with staff and management.

This order must be complied with by February 12, 2026

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 #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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:

Issued as as a CO (HP) on 2025-06-18 within Inspection #2025-1002-0003

This is the first 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.

COMPLIANCE ORDER CO #003 Dealing with complaints

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108
Dealing with complaints
s. 108.
(1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the

Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.
(2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.
(3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response.
(4) Subsections (2) and (3) do not apply with respect to verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received.
(5) Where a licensee is required to immediately forward a complaint under clause 26 (1) (c) of the Act, it shall forward it in a form and manner acceptable to the Director, and,
(a) during the Ministry's normal business hours, to the Director or the Director's

delegate; or
(b) outside normal business hours, using the Ministry's after hours emergency contact method.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1. Review and revise, as necessary, the Investigating and Responding to Complaints Policy to ensure it provides clear direction to all staff regarding the complaints procedure.
2. Complete in person education with all staff on the revised policy in (1).
3. Develop and implement a process for ensuring that:
(a) When a complaint is received related to the care of a resident or the operation of the home, that it is immediately reported to the Director in the manner set out in the regulations.
(b) Where the complaint alleges harm or risk of harm of one or more residents, an investigation is immediately intiated.
(c) a response that complies with O.Reg 246/22 s. 108, paragraph 3, is provided to the complainant within 10 business days of the receipt of the complaint.
(d) A documented record is kept in the home that includes the requirements set out in O.Reg 246/22 s. 108, paragraph 2.
3. Maintain a written record of the requirements under (1) (2) and (3). Documentation of education shall include the names of the staff, their designation, the date training was provided, the name of who provided the training, and a copy of training materials and documents utilized.

Grounds

1. The licensee has failed to ensure that a written complaint made to a registered

staff member, concerning the care of a resident, was dealt with as required. Specifically, on a day in October, 2025, a registered staff member received a verbal and written concern regarding the resident medication not being administered the day prior.

Inspector was unable to locate documentation related to the resolution of the complaint. It was confirmed with the ED that this concern would have required a response to the complainant, and confirmed this was not completed. Additionally, it was confirmed the written complaint was not forwarded to the Director, and a record was not maintained as outlined in the legislation.

Sources: Resident's progress notes; complaints record; Investigating and Responding to Complaints Policy #OP-AM-6.1 (March, 2025); Investigation folder for; Interviews with staff and management.

2. The licensee has failed to ensure that verbal complaints made to staff members concerning the care of a resident, were dealt with as required. Specifically, concerns regarding care, such as continence care, dressing, and medication administration not being provided to the resident were received verbally on a day in August, 2025, two days in September, 2025, and one day in October, 2025.

The Investigating and Responding to Complaints Policy (March, 2025) states that any complaint made to a staff member, whether verbal or written, shall be directed or communicated immediately to the Executive Director or appropriate designate. All investigations shall be conducted by the Executive Director or appropriate designate or a representative from Omni. During interviews with registered staff, they confirmed that they are to complete investigations into concerns, and follow-up with the complainant.

Inspector was unable to locate documentation related to the investigation and resolution of the complaints. It was confirmed with the DOC and ED that this concern would have required a response to the complainant, and confirmed this was not completed. Additionally, the DOC and ED confirmed the verbal complaints were not forwarded to the Director, and a record was not maintained as outlined in the legislation.

Sources: Residents progress notes; complaints record; Investigating and Responding to Complaints Policy #OP-AM-6.1 (March, 2025); Interviews with staff and management.

This order must be complied with by February 12, 2026

COMPLIANCE ORDER CO #004 Medication management system

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1. Review and revise, as necessary, the process surrounding medication incidents to ensure there is clear direction to staff on how to complete a medication incident, and how to notify the pharmacy service provider of the incident.
2. Complete in person education with all registered staff on the process for Narcotic

and Medication Counts, as well as the reviewed policy in (1) for Medication Incidents.
3. Develop and implement a process for ensuring that the policies for narcotic counts and medication incidents, are being complied.
4. Maintain a written record of the requirements under (1) (2) and (3). Documentation of education shall include the names of the staff, their designation, the date training was provided, the name of who provided the training, and a copy of training materials and documents utilized.

Grounds

The licensee has failed to ensure that their written policies related to Narcotic and Controlled Medication Counts and Medication Incident Reporting, were complied with. In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policies related to medication management are complied with.

Specifically, The Narcotic and Controlled Medication Counts policy indicates registered staff must document for the administration of the narcotic, or controlled substance on the resident's MAR and on the Combined Narcotic/Controlled Medication Count Record. A reconciliation of the medication on hand and medication on the Combined Narcotic/Controlled Medication Count Record must also be done at shift change, with any discrepancies immediately reported to the Director of Care. On a specified day in October, 2025, a reconciliation was not completed when registered staff member #115 was leaving, and another registered staff member was starting shift. Later that shift there was noted to be a discrepancy by the oncoming registered staff member, which was confirmed to not be immediately reported. Pharmapod medication incidents reported from May-June, 2025, noted there were seven incidents of narcotic administration policies not complied with.

The Medication Incident Reporting policy states, if there is an alternative defined medication incident report form, it is required to be completed with the information available around the incident and faxed to pharmacy. Medication incidents completed within Pharmapod showed three incidents were not reported to the pharmacy provider in April 2025, four in May 2025, one in June 2025, and two in September 2025. It was confirmed the discrepancies indicate the Pharmapod medication incidents were not faxed to pharmacy, and pharmacy was not aware of the incidents.

Sources: Documentation of Narcotic and Controlled Medication Counts Policy #7.5 (July, 2025); Medication Incident Reporting Policy #9.2 (July, 2025); Pharmapod safety report; Investigation folder for CI; Interviews with staff and management.

This order must be complied with by February 12, 2026

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

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
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

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.