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: July 16, 2025
Inspection Number: 2025-1213-0003
Inspection Type: Complaint Critical Incident Follow up
Licensee: Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.
Long Term Care Home and City: Maplewood, Brighton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 7-11, 14-16, 2025.
The following intake(s) were inspected:

- Intake: #00146190 - CI #2717-000007-25- Alleged resident to resident physical abuse.
- Intake: #00146493 - CI #2717-000008-25 and Intake: #00146608 - CI #2717-000009-25- Alleged resident to resident sexual abuse.
- Intake: #00146570 - Follow-up #: 1 to Compliance Order (CO) #001, in relation to FLTCA, 2021 - s. 25 (1)- Zero Tolerance of Abuse Policy with a Compliance Due Date of June 13, 2025
- Intake: #00147624 - CI #2717-000011-25- Fall of Resident resulting in injury.
- Intake: #00151312 - Complaint related to the discharge of a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1213-0002 related to FLTCA, 2021, s. 25 (1)

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

Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

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 (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 licensee has failed to ensure that a resident's written plan of care set out clear directions to staff who provide direct care regarding their transferring method. The resident's care plan indicated two different methods of transferring. A Registered Nurse (RN) indicated that only one of these transfer methods was currently in use for the resident.

Sources: Review of resident's care plan and Kardex; review of physiotherapy

recommendations; interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 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 interventions related to responsive behaviours, set out in a resident's plan of care, was provided to the resident as specified in the plan.
Specifically, the residents plan of care indicated a specific assessment tool was to be completed annually and with a change in status; as well as a second specific intervention to mitigate responsive behaviours. During interviews, it was confirmed these were not completed.

Sources: Review of resident's plan of care; progress notes, and completed assessments; interviews with staff and Administrator

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 failed to ensure that the incident of alleged abuse between two residents on a specified date in April, 2025 was immediately reported to the Director.

Sources: CI #2717-000007-25, health care records including progress notes for residents, interviews with PSW and the DOC.

WRITTEN NOTIFICATION: When licensee may discharge

NC #004 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 they were informed by a resident's physician 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 their discharge. Specifically, the Long Term Care Home (LTCH) received the direction to discharge the resident from Corporate Office, rather than the physician, who indicated they were notified of the residents discharge, after it had occurred.

Sources: Resident's progress notes, discharge letter, interviews with Physician and Administrator

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (a)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

The licensee has failed to ensure that the considered alternatives to discharge were trialed, prior to discharging a resident.
Specifically, the resident was transferred to hospital for assessment related to an increase in responsive behaviours on a specified day in June, 2025. The licensee had considered several interventions, however, these alternatives were not trialed, prior to discharging the resident.

Sources: Resident's progress notes and census; review of consultation notes; interview with Administrator

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

The licensee has failed to ensure a resident's substitute decision-maker was kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; prior to discharging the resident on a specified day in June, 2025.

Sources: Resident's progress notes and census; interview with resident's Power of Attorney and Administrator