

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: March 5, 2026

Inspection Number: 2026-1213-0001

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: Maplewood, Brighton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 2-5, 2026

The following intake(s) were inspected:

- Intake: #00166037 - CI #2717-000021-25 and Intake: #00167670 - CI #2717-000001-26: Alleged staff to resident verbal abuse
- Intake: #00166175 - CI #2717-000022-25: Outbreak Declared

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect

INSPECTION RESULTS

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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.

"Verbal abuse" means 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.

On a specific day in November, 2025, there was an alleged incident of witnessed verbal abuse from a staff member towards a resident of the home. This incident was not reported by the witness until January, 2026, and has not been investigated.

The staff member continued to work their scheduled shifts until a specified date in December, 2025, when a second incident of alleged verbal abuse occurred. During the Long Term Care Home's (LTCHs) internal investigation, it was confirmed that the resident appeared anxious and was noted to be crying during the interaction with the accused staff member.

Sources: LTCHs internal investigation notes; e-correspondence from Administrator on March 4, 2026; Interviews with staff

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WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 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's Zero Tolerance of Abuse and Neglect of Residents Policy states that

1. In cases where a staff member witnesses/suspects/hears about an act of abuse, once the resident is physically safe, the incident must be reported to a direct manager, nurse in charge, Director of Care or Executive Director
2. Any person who has reasonable grounds to suspect that abuse of a resident, by anyone, has occurred must immediately report the suspicion to the Ministry of Long Term Care.
3. For any Incident of alleged, suspected or actual abuse of any kind, the resident must be assessed by registered staff, and a skin assessment and pain assessment initiated and documented in the residents clinical record.

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On a specific date in December, 2025, there was an alleged incident of witnessed verbal abuse from a staff member towards a resident of the home. The DOC was not made aware of, or report the incident until three days after the incident.

Inspector could not locate a pain or skin assessment in the resident's clinical records for the date of the incident.

Sources: The Zero Tolerance of Abuse and Neglect of Residents Policy (May 2025); resident's clinical record for assessments; Internal investigation notes; Interview with staff

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.

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On a specific date in November, 2025, there was an alleged incident of witnessed verbal abuse from a staff member towards a resident of the home. This incident was not reported to the director until 44 days after the incident occurred.

Sources: CI #2717-000001-26; LTCHs internal investigation notes; interview with staff

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

During an observation on March 2, 2026, inspector noted a yellow isolation hanger on the door of a resident room, equipped with Personal Protective Equipment (PPE). Additional precautions signage could not be located at the point of care. Management confirmed that the resident room required additional contact and droplet precautions.

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Sources: Inspector observations on March 2, 2026; Interview with Management

**WRITTEN NOTIFICATION: Licensees who report investigations
under s. 27 (2) of Act**

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 112 (3)

Licensees who report investigations under s. 27 (2) of Act

s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

On a specific date in January, 2026, a critical incident was submitted to report an alleged incident of verbal abuse from a staff member towards a resident of the home. The administrator confirmed the investigation has been paused. As of the date of this inspection, the licensee had failed to provide a final report to the Director.

Sources: CI #2717-000001-26; e-correspondence from Administrator on March 4, 2026