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

London District
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Public Report

Report Issue Date: January 26, 2026
Inspection Number: 2026-1270-0001
Inspection Type: Critical Incident
Licensee: Omni Quality Living (Southwest) Limited Partnership by its general partner Omni Quality Living (Southwest) GP Ltd.
Long Term Care Home and City: Park Lane Terrace, Paris

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 12-14, 16, 20, 22, 23, 26, 2026.

The following intake(s) were inspected:

- Intake: #00162461 - Critical Incident (CI) 2779-000025-25: fall of a resident
- Intake: #00164016 - CI 2779-000028-25: fall of a resident
- Intake: #00164023 - CI 2779-000029-25: fall of a resident

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

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.

Interview with the ADOC/Falls lead confirmed that they did not follow the direction in the plan of care to bring a resident to the nurses station for monitoring when they left the resident unattended and the resident fell while self transferring.

Sources: Critical Incident (CI) 2779-000028-25, review of the resident's clinical records, interviews with the PSW and ADOC/Falls Lead.