

**Ministry of Long-Term Care**

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

**Central East District**

33 King Street West, 4th Floor  
Oshawa, ON, L1H 1A1  
Telephone: (844) 231-5702

## Public Report

**Report Issue Date:** May 8, 2025

**Inspection Number:** 2025-1252-0003

**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:** Pleasant Meadow Manor, Norwood

## INSPECTION SUMMARY

This is a modified Public Inspection Report (IR). The report was modified to correct errors in the numbering of Non-Compliances (NCs) that were present in the original Public IR.

The inspection occurred onsite on the following date(s): April 28 - 30, 2025 and May 1, 2, 5 - 8, 2025

The following intake(s) were inspected:

- Follow-up #1 - CO #003 / 2025-1252-0001, O. Reg. 246/22 - s. 140 (3) (b) (ii) Administration of drugs, CDD March 31, 2025
- Follow-up #1 - CO #002 / 2025-1252-0001, O. Reg. 246/22 - s. 79 (1) 5. Dining and snack service, CDD March 31, 2025
- Follow-up #1 - CO #001 / 2025-1252-0001, O. Reg. 246/22 - s. 55 (2) (b) (iv) Skin and wound care, CDD March 31, 2025
- An intake related to a critical incident for alleged physical abuse of a resident by a staff member

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- An intake related to a critical incident for improper care of a resident by staff.
- An intake related to a critical incident for alleged verbal abuse of resident by staff.
- An anonymous complaint regarding concerns around personal care and housekeeping.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2025-1252-0001 related to O. Reg. 246/22, s. 79 (1) 5.  
Order #001 from Inspection #2025-1252-0001 related to O. Reg. 246/22, s. 55 (2) (b) (iv)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #003 from Inspection #2025-1252-0001 related to O. Reg. 246/22, s. 140 (3) (b) (ii)

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

Resident Care and Support Services  
Skin and Wound Prevention and Management  
Food, Nutrition and Hydration  
Medication Management  
Infection Prevention and Control  
Prevention of Abuse and Neglect  
Reporting and Complaints

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Oral Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)**

Oral care

s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,  
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received morning oral care to maintain the integrity of their oral tissue.

A Critical Incident System (CIS) report was received by the Director related to improper/incompetent treatment or care of a resident that results in harm or risk to a resident.

A resident's care plan indicated that they required oral care twice daily. The home's investigation notes indicated that a staff member did not provide morning oral care for the resident. The Administrator confirmed that the staff member did not provide oral care to the resident.

**Sources:** CIS, care plan, the home's investigation notes, and interview with the Administrator.

### WRITTEN NOTIFICATION: Transferring and Positioning Techniques

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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 safe transferring techniques were used when assisting a resident.

A CIS report was received by the Director related to improper/incompetent treatment or care of a resident that resulted in harm or risk to a resident.

A resident's care plan stated that they required a two person staff assistance with transfers. The home's investigation notes indicated that a staff member transferred the resident without using two person assistance. The Administrator confirmed that the resident required a two person staff assistance for transfers, and that the staff member transferred the resident without assistance.

**Sources:** CIS, care plan, the home's investigation notes, and interview with the Administrator.

**WRITTEN NOTIFICATION: Residents' Bill of Rights**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.**

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,

ii. give or refuse consent to any treatment, care or services for which their consent is

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required by law and to be informed of the consequences of giving or refusing consent,

1.A resident's right to have their participation in decision-making and consent was not respected by two staff members during personal care. On a specified date, the resident was receiving care and asked staff to stop due to discomfort. The staff members did not stop and the resident had to yell to get them to listen.

**Sources:** Interviews with the resident, statements and investigation notes, interview with the Administrator.[741755]

2.A Resident's right to have their participation in decision-making and consent was not respected by a staff member during personal care. On a different day, the resident was receiving care and asked the staff member to stop as they felt uncomfortable. The staff member did not stop, and the resident had to yell to get them to listen.

**Sources:** Interviews with the resident, statements and investigation notes, interview with the Administrator.

**WRITTEN NOTIFICATION: Licensee must comply**

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

**Non-compliance with: FLTCA, 2021, s. 104 (4)**

Conditions of licence

s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The Director of Care (DOC) or designate, along with Care RX Pharmacist failed to develop a policy for Personal Support Workers to apply medicated treatment cream and shampoos. The licensee has not trained all registered staff and PSW's on the policy and kept documentation of who provided the training, and the date of the

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education.

**Sources:** Policy named Application of ointments and treatment creams, emails and interviews with staff.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #004**

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 an order under s. 155 of the Act.

**Compliance History:**

CO issued January 23, 2025 under O. Reg 246/22, s. 140 (3) (b) (ii) 2025-1252-0001

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

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(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.

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