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

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

Public Report

Report Issue Date: August 1, 2025

Inspection Number: 2025-1252-0005

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

The inspection occurred onsite on the following date(s): July 22-25, 28-31, August 1, 2025

The following intake(s) were inspected:

- Intake: #00145429 - ARI - Respiratory Syncytial Virus Outbreak.
- Intake: #00145431 - Fall of a resident.
- Intake: #00147018 - Follow-up #: 2 - O. Reg. 246/22 - s. 140 (3) (b) (ii) $500.00 RIF
- Intake: #00149257 - Fall of a resident.
- Intake: #00150957 - Anonymous complaint.
- Intake: #00151794 - Complaint regarding a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found 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:

Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that the complaint of abuse of resident, was immediately reported to the Director.

Sources: resident clinical record, interviews with resident, and staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.

Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The home failed to ensure that the long-term corrective actions identified in the Critical Incident Report (CIR) were incorporated into the plan of care for a resident.

Sources: CIR, resident's careplan, and interview with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure a post-fall assessment was completed for a resident using a clinically appropriate tool, as required. Two staff confirmed the assessment was not done.

Sources: Resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to comply with the home's Pain Assessment Policy, when a resident's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose

when they experienced a change in status and pain control was a concern.

In accordance with O. Reg. 11 (1) (b), the licensee is required to ensure that written policies developed for pain assessment were complied with.

Specifically, the home's policy indicated that a comprehensive pain assessment would be complete as required when a resident experienced a change of status by reporting pain in their hip.

Sources: Resident's clinical record, Pain Assessment policy, Pain Management Policy, interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The home failed to monitor a resident, after a positive respiratory test. Despite directives from Peterborough Regional Hospital and Public Health to implement certain precautions, the home did not follow through. During an respiratory outbreak, records show that a resident was not monitored following their readmission.

Sources: Daily Infection Control Tracking Sheets, Progress notes for a resident, Peterborough Regional Hospital Discharge Summary Report, Public Health Transfer Records, Interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately

informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act was immediately reported to the Director as declared by Public Health. The home submitted a Critical Incident Report to the Director late.

Sources: Critical Incident Report and interview with staff.

WRITTEN NOTIFICATION: Reports re: critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
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):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to inform the Director within one business day of a resident's fall which resulted in a significant change in the resident's health condition. The licensee was aware on a certain date, that the resident had sustained an injury and would require surgical intervention. Notification was called in to the afterhours line. A Critical Incident Report was submitted to the Director late.

Sources: Critical Incident Report, LTC Homes After Hours Report, resident's clinical record, home's interview with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Sources: Electronic records for a resident, interviews with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

1.Provide in person education to all RNs, RPNs and any other nurses (including agency) on the home's Care of a Resident with an specific illness, and Specimen Collection policies. Include a specific resident as a case study for educational purposes.

2.Keep records of the education content, dates it was completed, educator and the signatures of all who attended.

3.Provide documentation of the education content, dates it was completed, name of the educator and signatures to the inspector upon request.

Grounds

Introduction
The licensee failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident to ensure that their assessments were integrated and were consistent with and complemented each other. A resident experienced specific symptoms with timely assessments delayed initially, and the necessary evaluations to manage their

medical condition were not provided during the subsequent episode.

Rationale and Summary

A resident experienced prolonged specific symptoms but did not receive timely or coordinated care. There were delays in assessments, missed documentation, and poor follow-up on test results. Communication between nursing staff, nurse practitioners, and physicians was lacking, and hydration monitoring was inadequate. A lab test was mishandled twice, and abdominal assessments were not consistently recorded. Despite being assessed by the Registered Dietician (RD) as high nutritional risk, documentation did not reflect specific concerns. The resident deteriorated and passed away. The licensee failed to ensure collaborative and integrated assessments among care providers.

Sources: CIR, resident's clinical record, homes policies, interview with DOC.

This order must be complied with by September 26, 2025.

COMPLIANCE ORDER CO #002 Duty to protect

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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.

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

1.Educate a RN on assessments required when a resident demonstrates a change in baseline status, and when to notify the physician / NP when a resident has a change in condition.

2.Audit a RN's documentation daily for a period of four weeks to review and identify situations where assessment of a resident who is exhibiting a change in status is required. When situations where assessment was identified as required and not completed, provide remedial education.

3.Make available to the inspector upon request documentation of the education that was provided, the date it was provided and the name of the person who provided the education and the results of the audit.

Grounds

Introduction
The licensee failed to protect a resident from neglect when a Registered Nurse (RN) did not conduct an assessment when the resident demonstrated a significant change in status.

Rationale and Summary

A critical incident and complaint were submitted regarding a resident's unexpected death. The resident became confused and unresponsive, showing signs of distress. The RN failed to conduct a full assessment, did not contact the physician, and waited for SDM direction. The DOC confirmed this was a change from baseline and that the RN's inaction constituted neglect. The licensee failed to protect the resident by not ensuring timely reassessment and appropriate clinical response.

Sources: CIR, interviews with DOC and resident's SDM, review of a resident's clinical record and home's investigation file interview documentation with RN.

This order must be complied with by September 26, 2025

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Intake: #00147018 - Follow-up #: 2 - O. Reg. 246/22 - s. 140 (3) (b) (ii)

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

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.