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: September 12, 2025
Inspection Number: 2025-1252-0006
Inspection Type: Complaint 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: Pleasant Meadow Manor, Norwood

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3-5, 8-12, 2025.

The following intake(s) were inspected:

- An intake regarding a complaint related to multiple care concerns for a resident.
- An intake regarding a resident to resident altercation.
- An intake regarding a complaint related to staffing and training.

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

- Skin and Wound Prevention and Management
- Continence Care
- Resident Care and Support Services
- Housekeeping, Laundry and Maintenance Services
- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
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:
4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that a resident had the right to freedom from abuse. On a specific date, a resident was physically expressive towards a co-resident.

Sources: A critical incident report, resident clinical records, the licensee's Responsive Behaviour Policy, the licensee's Prevention of Abuse Policy, 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 (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 plan of care set out clear directions for bathing.

Sources: Observation, a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
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,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff collaborated with the MD in the development and implementation of the plan care when documenting the location for a specific treatment.

Sources: The licensee's Medication Policy, a resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 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 a resident's plan of care was followed when the resident was observed being served a beverage in the dining room and that the resident's assistive device was applied as specified in the residents plan of care.

Sources: Observation, a resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure the plan of care was reviewed and revised when it was not effective related to the level of assistance required for toileting a resident.

Sources: A resident’s clinical records, interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #006 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 has failed to ensure that the written policy for promoting zero tolerance of abuse and neglect was complied with when an assessment for a resident was incomplete.

Sources: A resident's clinical records, the licensee's Policy for Prevention of Abuse, interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #007 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 a resident received the appropriate level of assistance when transferring to the toilet.

Sources: A resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that was specifically for skin and wound assessment when the resident presented with altered skin integrity.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's area of altered skin integrity was reassessed at least weekly.

Sources: The licensee's Wound Assessment and Documentation Policy, a resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the needs of a resident, including assessment. After an altercation with a co-resident an assessment was incomplete.

Sources: A critical incident report, the licensee's Policy for Responsive Behaviours, a resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Altercations and other interactions

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident and other residents, including, identifying factors, based on information provided through observation, that could potentially trigger such altercations. The care plan for a resident who exhibited responsive behaviour was not updated to reflect the behaviours or to include strategies to reduce risk.

Sources: The licensee's Policy for Responsive Behaviours, and a resident's clinical records.

WRITTEN NOTIFICATION: Altercations and other interactions

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that required interventions were implemented to reduce the risk of altercations. On a certain date a resident was observed without a required intervention in place.

Sources: A critical incident report, observations, a resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure current procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. A resident's plan of care was not updated with responsive behaviour and interventions until a later date.

Sources: A resident's clinical records, the licensee's Policy for Responsive Behaviours, interviews with staff.

WRITTEN NOTIFICATION: Medication management system

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the home's medication management system when the staff did not indicate the location to apply a resident's medication treatment. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the Medication Management system were complied with. The policy was not followed for a resident to indicate the location for specific treatments.

Sources: The licensee's Medication Policy, a resident's clinical records, and interviews with staff.