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**
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# Public Report

**Report Issue Date:** October 31, 2025

**Inspection Number:** 2025-1252-0007

**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): October 15 - 17, 20 - 24, 27 – 31, 2025.

The following intake(s) were inspected:

- Follow-up #1, for CO #002 from inspection #2025-1252-0005, FLTCA, 2021, s. 24 (1) Duty to protect with a CDD September 26, 2025.

- Follow-up #1 for CO #001 from inspection #2025-1252-0005, FLTCA, 2021, s. 6 (4) (a), Plan of care with a CDD September 26, 2025.

- An intake regarding allegations of neglect of a resident by staff.

- An intake regarding allegations of emotional abuse to a resident by staff.

- An intake regarding allegations of resident neglect.

- An intake regarding allegations of resident neglect.

- A complaint regarding allegations of improper care of a resident.

- An intake regarding a resident fall that resulted with an injury.

- An intake regarding an unexpected death of a resident.

- An anonymous complaint with allegations of improper care of a resident.
- A complaint regarding care concerns of a resident.
- An intake regarding an unexpected death of a resident.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1252-0005 related to FLTCA, 2021, s. 24 (1)
Order #001 from Inspection #2025-1252-0005 related to FLTCA, 2021, s. 6 (4) (a)

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Pain Management
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 (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 that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

An anonymous complaint was received by the Ministry of Long-Term Care (MLTC) regarding an improper transfer of the resident. Observations of the resident's room revealed a hygiene sling that was unlabeled. The resident's care plan did not indicate a sling size for the resident. The Infection Prevention and Control (IPAC) Manager indicated that all slings should be labelled with the resident's name. The home's policy indicated that registered staff shall document the type of transfer and/or lift and appropriate transfer aids on the plan of care and communicate this information at shift-to-shift report. The unit shift-to-shift report did not indicate sling size for the resident.

**Sources:** A resident's care plan, observations of a resident's room, unit shift-to-shift report, a policy and interview with staff.

## WRITTEN NOTIFICATION: Based on assessment of resident

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (2)**
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that a resident's care set out in the plan of care for the level of assistance related to meals was based on an assessment of their needs. The RD confirmed the resident's plan of care was not updated to reflect the assessed level of assistance required.

**Sources:** A resident's clinical records and an interview 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 (5)**

Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was provided the opportunity to participate fully in the development and implementation of the resident's plan of care when staff failed to inform them that the resident had contacted an outside resource. The resident's SDM indicated they would have visited the resident to provide emotional support if they had known the resident had called an outside resource. The Executive Director (ED) confirmed that registered staff should have notified the resident's SDM.

**Sources**: Progress notes, internal investigation records, and interviews with the resident's SDM, and the ED.

## 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.

1. The licensee has failed to ensure that a resident's plan of care was followed when the registered staff failed to respond to the resident's request for staff assistance. Registered Nurse (RN) #122 indicated that RN #123 made them aware that the resident had called for assistance, but they did not respond to assess the resident's needs.

**Sources:** Care plan, progress notes, internal investigation records, and interviews with staff.

2. The licensee has failed to ensure that a resident's plan of care was followed when the resident's vital sign readings exceeded the normal range on multiple occasions. The care plan directed staff to monitor the resident's vital sign and notify the physician of any abnormal readings.

**Sources:** Care plan, vital sign records, progress notes, and interviews with staff.

## WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1.The licensee has failed to ensure that the documentation accurately reflected the continence care provided for a resident, and that the care was provided as set out in the plan of care. The home's internal investigation determined that the documentation of continence care and turning and positioning was inaccurately documented during the night shift.

**Sources:** A resident's clinical records, the home's internal investigation records, a Critical Incident (CI) , and interviews with staff.

2.The licensee has failed to ensure that the provision of care included documentation confirming that safety checks were completed, as directed by the manager.

**Sources:** Progress notes, internal investigation records, and interview with staff.

## WRITTEN NOTIFICATION: Duty to protect

NC #006 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.

The licensee has failed to ensure that a resident was protected from emotional abuse by anyone.

A report was made that a resident was spoken to rudely by two Personal Support

Workers (PSW). The home's investigation concluded that the tone used by both staff members during the interaction was rude. The resident reported feeling upset and uncomfortable as a result. The ED confirmed that the investigation founded emotional abuse.

**Sources:** A CI, the home's investigation records, and interviews with a resident and the ED.

## WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 26 (1) (c)**
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint from a resident's SDM concerning the care of the resident was immediately forwarded to the Director. The ED confirmed that this information was not reported immediately to the Director.

**Sources:** A CI, complaint letter, and interview with the ED.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 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 has failed to ensure that an incident of improper or incompetent treatment or care of a resident was reported to the Director immediately.

An allegation of improper care was reported to the ED when a resident was transferred incorrectly by a staff member. The ED confirmed that this information was not reported immediately to the Director.

**Sources:** A resident's care plan, the home's investigation records, and interview with the ED.

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #009 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 resident was improperly transferred using a mechanical lift. The home's investigation records indicated that a PSW transferred the resident without assistance. The resident's care plan indicated that they required a two staff assistance to transfer. The ED acknowledged that the resident required a two person staff assistance for transfers, and that the PSW transferred the resident without assistance.

**Sources:** A resident's care plan, the home's investigation records, and interview with the ED.

## WRITTEN NOTIFICATION: Skin and wound care

NC #010 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's altered skin integrity was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. An RN and the Director of Care (DOC) confirmed the Skin and Wound evaluation note should have been utilized to describe the resident's altered skin integrity. They acknowledged that registered nursing staff had not completed the clinically appropriate skin and wound evaluation note.

**Sources:** Progress notes, skin and wound evaluation notes and interviews with staff.

## WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)**
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection when exhibiting altered skin integrity. The resident experienced altered skin integrity, and the prescribed medicated treatment cream was ordered by the physician several days after the initial assessment was reported to the registered staff. An RN and the DOC

acknowledged that there was a delay in the resident's skin treatment.

**Sources:** Progress notes, electronic Treatment Administration Record (eTAR), internal investigation records, and interviews with staff.

## WRITTEN NOTIFICATION: Skin and wound care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that a resident who was unable to reposition themself in bed, was turned and repositioned every two hours. The home's internal investigation confirmed that the resident was not turned or positioned as required in their plan of care.

**Sources:** A resident's clinical records, the home's internal investigation records, a CI, and interviews with staff.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)**
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident received sufficient changes of their continence care product to remain clean, dry, and comfortable. The resident reported

not receiving any continence care during the night shift and was found to be incontinent. The home's internal investigation confirmed that the resident was not toileted or checked in accordance with their plan of care.

**Sources**: A resident's clinical records, the home's internal investigation records, a CI, and interviews with staff.

## WRITTEN NOTIFICATION: Pain management

NC #014 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 has failed to ensure that a resident's pain was assessed using a clinically appropriate tool when their pain was not relieved by initial interventions. The resident received routine pain medication and required breakthrough pain medication on several occasions. A PSW, RN, and Registered Practical Nurse (RPN) indicated the resident had signs of pain but was not able to communicate. The resident's Pain Assessment in Advanced Dementia Scale (PAINAD) scores were usually a score of three. The RN confirmed a clinically appropriate tool to assess the resident's pain should have been completed when the resident required as needed pain medication.

**Sources:** Progress notes, electronic Medication Administration Record (eMAR), care plan, Pain Management Program Policy, and interview with staff.

## WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 74 (2) (b)**
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(b) the identification of any risks related to nutritional care and dietary services and hydration;

The licensee has failed to ensure the identification of any risks related to nutritional care, dietary services, and hydration was completed for a resident when the Nutritional Care Quarterly Review was not completed over an extended period.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the nutritional care and hydration program was complied with.

Specifically, the licensee policy for Nutritional Care Quarterly Review directed the RD to complete a Nutritional Risk Assessment, Nutrition and Hydration Assessment, care plan review and update, and summary progress note quarterly. The resident's clinical records indicated that a quarterly assessment was not completed for an extended period of time.

**Sources**: A resident's clinical records, Nutritional Care Quarterly Review policy, and interviews with staff.

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.**
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):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that a resident’s sudden death was immediately reported to the Director, as required. The ED confirmed that the resident’s SDM had raised concerns regarding the circumstances of the resident’s death and acknowledged that a CI should have been submitted to the Director.

**Sources:** A CI, and interviews with a resident's SDM, and the ED.

## WRITTEN NOTIFICATION: Safe storage of drugs

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that a resident's drugs were stored in an area or a medication cart that was secured and locked. The resident SDM found the resident's morning medication left unattended in the resident's room.

**Sources**: Internal Investigation Records, and interview with staff.

## WRITTEN NOTIFICATION: Administration of drugs

NC #018 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 resident received their prescribed oral medication, as ordered. The DOC confirmed the resident had not received their oral medication when a registered staff had left the resident's medication at their bedside.

**Sources**: Progress notes, eMAR, internal investigation records, and interview with the DOC.

## WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 147 (1)**
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. The resident's SDM found the resident's morning medication in the resident's room and reported to an RPN. No further action was taken by the RPN to assess the resident's health or document that the resident had not received their medication, as prescribed. A medication incident report was not immediately initiated, and the RPN did not notify the physician, DOC and pharmacy service provider.

**Sources:** Internal Investigation Report, progress notes, and interview with the DOC.