

# 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

#### **Ottawa District**

347 Preston Street, Suite 410 Ottawa, ON, K1S 3J4 Telephone: (877) 779-5559

## **Public Report**

Report Issue Date: July 8, 2025

**Inspection Number:** 2025-1177-0003

**Inspection Type:**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: Rosebridge Manor, Jasper

## **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): July 2, 3, and 7, 2025.

The following Critical Incident (CI) intake(s) were inspected:

- Intake 00149795 (CI 2671-000011-25) fall of a resident resulting in injury;
  and
- Intake 00149834 (CI 2671-000013-25) hospital transfer of a resident with injury of unknown etiology.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services Falls Prevention and Management

## **INSPECTION RESULTS**



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### **WRITTEN NOTIFICATION: Plan of Care**

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

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, (b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when specific care needs for that resident changed after a fall with injury.

Sources: Resident care plan; Documentation Survey Report, June 2025; progress notes; and interviews with the Director of Care (DOC), Registered Nurse (RN) #101, and Personal Support Worker (PSW) #103.