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: October 24, 2025
Inspection Number: 2025-1056-0004
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: The Willows Estate Nursing Home, Aurora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15-17, 20-24, 2025

The following intake(s) were inspected:
-An intake related to a complaint regarding the care of a resident
-An intake related to the fall of a resident
-An intake related to a complaint regarding a fall of a resident

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

Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

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) 19. iv.
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,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure that residents' right to privacy of health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential when residents' personal health information was observed posted in a resident hallway.

Sources: Observations and interview with the home's Director of Care (DOC).

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #002 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 failed to immediately forward to the Director, a written complaint concerning the care of a resident. A written complaint was sent by a resident's Substitute Decision Maker (SDM) to the home inquiring about the resident's care. The home's Administrator acknowledged that the complaint was not forwarded to the Director.

Sources: Written complaint and interview with the home's Administrator.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 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 failed to ensure that staff utilized a safe transferring technique when assisting a resident. A resident was assisted manually by staff members without the use of a mechanical lift. The DOC confirmed that the home's expected practice would be for staff to utilize a mechanical lift to assist a resident.

Sources: Home's Internal Investigation Notes, Home's Resident Falls and Post Fall Assessment Policy, Home's Mandatory Lift and Transfer Procedures Policy, and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to comply with the home's Resident Falls and Post Fall Assessment Policy, when the Neurological Vital Signs Post Head Injury Routine assessment form for a resident was not completed in its entirety for the designated intervals, as per the associated tool and the home's policy.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's policy indicated that a neurological assessment shall be initiated for any unwitnessed fall and will continue for 72 hours post fall at the intervals required on the Neurological Vital Signs Post Head Injury Form.

A staff member acknowledged that the paper form only recorded vital signs and that the other aspects of the assessment were not completed. The DOC only located one fully completed interval documented in the electronic documentation system.

Sources: Clinical records for a resident, Home's Resident Falls and Post Fall Assessment Policy, and interviews with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that a response to a written complaint regarding the care of a resident was provided that complied with paragraph 3 within 10 business days of receipt of the complaint. The home's Administrator confirmed receipt of a written complaint, however, they acknowledged that a written response that complied with paragraph 3 was not provided to the complainant.

Sources: Written complaint and interview with the home's Administrator.

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