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

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

Public Report

Report Issue Date: October 22, 2025
Inspection Number: 2025-1213-0004
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: Maplewood, Brighton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 20, 21, 2025

The following intake(s) were inspected:

- Intake: #00148786 - CI #2717-000012-25 - Outbreak declared
- Intake: #00152581 - CI #2717-000014-25 - Fall of resident resulting in injury

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure there were hip protectors readily available for a specified resident. Specifically the resident did not have hip protectors applied on July 29 and 30, 2025 and October 20, 2025. Staff confirmed that hip protectors were not applied due none being readily available.

Sources: Review of resident's progress notes and care plan; Inspector observations on October 20, 2025; Interviews with multiple staff.