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: May 8, 2025

Inspection Number: 2025-1252-0003

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): April 28 - 30, 2025 and May 1, 2, 5 - 8, 2025

The following intake(s) were inspected:

- Follow-up #1 - CO #003 / 2025-1252-0001, O. Reg. 246/22 - s. 140 (3) (b) (ii) Administration of drugs, CDD March 31, 2025
- Follow-up #1 - CO #002 / 2025-1252-0001, O. Reg. 246/22 - s. 79 (1) 5. Dining and snack service, CDD March 31, 2025
- Follow-up #1 - CO #001 / 2025-1252-0001, O. Reg. 246/22 - s. 55 (2) (b) (iv) Skin and wound care, CDD March 31, 2025
- An intake related to a critical incident for alleged physical abuse of a resident by a staff member
- An intake related to a critical incident for improper care of a resident by staff.
- An intake related to a critical incident for alleged verbal abuse of resident by staff.
- An anonymous complaint regarding concerns around personal care and housekeeping.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1252-0001 related to O. Reg. 246/22, s. 79 (1) 5.
Order #001 from Inspection #2025-1252-0001 related to O. Reg. 246/22, s. 55 (2) (b) (iv)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #003 from Inspection #2025-1252-0001 related to O. Reg. 246/22, s. 140 (3) (b) (ii)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Oral Care

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

Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received morning oral care to maintain the integrity of their oral tissue.

A Critical Incident System (CIS) report was received by the Director related to improper/incompetent treatment or care of a resident that results in harm or risk to a resident.

A resident's care plan indicated that they required oral care twice daily. The home's investigation notes indicated that a staff member did not provide morning oral care for the resident. The Administrator confirmed that the staff member did not provide oral care to the resident.

Sources: CIS, care plan, the home's investigation notes, and interview with the Administrator.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC # 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 CIS report was received by the Director related to improper/incompetent treatment or care of a resident that resulted in harm or risk to a resident.

A resident's care plan stated that they required a two person staff assistance with transfers. The home's investigation notes indicated that a staff member transferred the resident without using two person assistance. The Administrator confirmed that the resident required a two person staff assistance for transfers, and that the staff member transferred the resident without assistance.

Sources: CIS, care plan, the home's investigation notes, and interview with the Administrator.

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. ii.
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,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

1.A resident's right to have their participation in decision-making and consent was not respected by two staff members during personal care. On a specified date, the resident was receiving care and asked staff to stop due to discomfort. The staff members did not stop and the resident had to yell to get them to listen.
Sources: Interviews with the resident, statements and investigation notes, interview

with the Administrator.[741755]

2.A Resident's right to have their participation in decision-making and consent was not respected by a staff member during personal care. On a different day, the resident was receiving care and asked the staff member to stop as they felt uncomfortable. The staff member did not stop, and the resident had to yell to get them to listen.
Sources: Interviews with the resident, statements and investigation notes, interview with the Administrator.

WRITTEN NOTIFICATION: Licensee must comply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The Director of Care (DOC) or designate, along with Care RX Pharmacist failed to develop a policy for Personal Support Workers to apply medicated treatment cream and shampoos. The licensee has not trained all registered staff and PSW's on the policy and kept documentation of who provided the training, and the date of the education.

Sources: Policy named Application of ointments and treatment creams, emails and interviews with staff.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
CO issued January 23, 2025 under O. Reg 246/22, s. 140 (3) (b) (ii) 2025-1252-0001

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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