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: July 30, 2025
Inspection Number: 2025-1218-0003
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: Riverview Manor Nursing Home, Peterborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23 - 25, 28 - 30, 2025

The following intake(s) were inspected:
· Intake: #00149306 - Physical abuse of a resident by a resident.
· Intake: #00149427 - Improper care to a resident.
· Intake: #00150435 - Physical abuse of resident by staff.
· Intake: #00150699 - Physical abuse of a resident by a resident.

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

Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that registered staff and the Physician collaborated with each other in the assessment of a resident's responsive behaviours and that their assessments were integrated and consistent, and complemented each other. The resident's clinical records over a specified period indicated they had responsive behaviours when staff tried to provide them care. During this period, assessments were completed related to these responsive behaviours. Registered Staff (RN) confirmed there was no documentation that the registered staff collaborated with the Physician regarding the results of the assessments or the resident's ongoing responsive behaviours when staff tried to provide them care.

Sources: Policy-Caring for a Resident who Refuses or is Resistive to Care or Treatment, clinical records, prescribers order sheet, Staff to Physician communication binder, interview with RN.

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

The licensee has failed to ensure that an intervention set out in a resident's plan of care was provided to the resident as specified in the plan. On a specified date, the resident reported they had a physical expression toward a co-resident. Registered Nurse (RN) confirmed the intervention was not in place on that date. The resident's plan of care indicated they required the intervention to deter other residents from wandering in.

Sources: Critical Incident Reports (CIR), resident's clinical records, Shift report, and interview with RN.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that a resident received assistance from staff to manage their continence care. The Interim Director of Care (DOC) confirmed that on

a specified date, the resident required staff assistance to maintain their continence and did not receive the assistance they required, as a result, the resident had reddened skin.

Sources: CIR, resident's clinical records, interview with the Interim DOC.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that procedures and interventions were implemented by a Personal Support Worker (PSW) when a resident exhibited responsive behaviours. The resident's plan of care and the home's policy indicated to leave the room when a resident exhibits responsive behaviours and reapproach later. The Investigation notes indicated when the resident had responsive behaviours, the PSW did not stop care, and the resident's response was a physical expression towards staff. The Administrator confirmed the result of the investigation was that the PSW did not stop the care when the resident exhibited responsive behaviours.

Sources: Policy titled- Caring for a Resident who Refuses or is Resistive to Care or Treatment, clinical records, investigation notes, Interview with RPN and the

Administrator.

WRITTEN NOTIFICATION: Notification re incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident's substitute decision-maker was immediately notified of the outcome of the investigation when it was completed. The Interim Executive Director confirmed the resident's substitute decision-maker was not immediately informed of the results of the investigation.

Sources: CIR, clinical records, investigation notes, interview with Interim Administrator.

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