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: June 4, 2025

Inspection Number: 2025-1056-0003

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: The Willows Estate Nursing Home, Aurora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22 - 23, 26 - 30, 2025 and June 2 – 4, 2025.

The following intakes were inspected:
- An intake from Inspection 2025-1056-0001, related to O. Reg. 246/22 - s. 57 (1) 1, with a Compliance Due Date (CDD) of May 12, 2025.
- An intake from Inspection 2025-1056-0001, related to FLTCA, 2021 - s. 24 (1), with a CDD May 12, 2025.
- An intake from Inspection 2025-1056-0001, related to O. Reg. 246/22 - s. 40, with a CDD May 12, 2025.
- An intake from Inspection 2025-1056-0001, related to O. Reg. 246/22 - s. 120 (1), with a CDD May 12, 2025.
- Two intakes were related to complaints of a resident's falls prevention and management, and responsive behavior.
- An intake was related to a Critical Incident of a resident's care and support services.
- An intake was related to the home's pest control program.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1056-0001 related to FLTCA, 2021, s. 24 (1).

Order #002 from Inspection #2025-1056-0001 related to O. Reg. 246/22, s. 40.

Order #003 from Inspection #2025-1056-0001 related to O. Reg. 246/22, s. 57 (1) 1.

Order #004 from Inspection #2025-1056-0001 related to O. Reg. 246/22, s. 120 (1).

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee shall ensure that any actions taken with respect to the resident under a program, including interventions were documented. As per the resident's electronic health records, the resident was deemed to

have a moderate risk for a condition and had recently experienced episodes of such condition. A review of the home's policy on resident care planning had directed the registered staff to develop a care plan that contained goals and interventions reflective of the resident's care needs. The resident's electronic care plan was reviewed and contained no goals nor interventions related to the identified condition.

Sources: resident's electronic health records, home's policy on resident care planning, and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Responsive behaviors

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee has failed to ensure that behavioral triggers were identified for the resident when they exhibited responsive behavior. The resident had experienced a behavioral episode on an identified date. As per the home's policy on supporting a resident with responsive behavior it directed the staff to identify and chart behavioral triggers in the resident's care plan. When reviewed, the resident's behavioral trigger was not identified and charted in their electronic care plan.

Sources: resident's electronic health records, and interview with the DOC.

WRITTEN NOTIFICATION: Responsive behaviors

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments,

reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the need of the resident, including assessments, were documented when they exhibited responsive behaviors.

1. A review of the resident's electronic health records indicated that a behavioral monitoring tool was initiated on several dates with the purpose of capturing the resident's behavior. When reviewed, multiple sections of the assessment tool were undocumented.

Sources: resident's electronic health records and chart, and interview with the DOC.

2. A review of the home's policy on the Violence Assessment Tool (VAT) directed nursing to complete such assessment on a quarterly basis. When reviewing the resident's quarterly VAT assessment, several sections of the tool were incomplete.

Sources: resident's electronic health records, VAT tool, home's policy on the VAT, and interview with the DOC.

3. A review of the home's policies on supporting a resident with responsive behaviors and the behavioral support assessment directed the staff to complete a comprehensive behavioral assessment on a quarterly basis. When reviewed, such quarterly assessment was not completed between January and March 2025 for the resident.

Sources: resident's electronic health records, chart, BSO binder, and interview with the DOC.

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