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

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Public Report

Report Issue Date: May 21, 2025
Inspection Number: 2025-1319-0002
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: Forest Hill, Kanata

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13, 14, 15, 20, and 21, 2025.

The following intake(s) were inspected:

- Intake: #00142378 - related to alleged resident to resident abuse.

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 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 the care set out in a resident's plan of care was provided to the resident as specified in their plan. Specifically, a resident's plan of care indicated for the resident to be monitored using Behavior Support Ontario - Dementia Observation System (BSO-DOS), which was not completed following the reported incident of alleged resident-to-resident abuse.

Sources: Progress notes, Critical Incident Report and interview with 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 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that written approaches to care, including identification of behavioral triggers that may result in responsive behaviors were developed to meet the needs of residents with responsive behaviors. Specifically, a resident has identified behavioral triggers that may result in responsive behaviors

and these behavioral triggers were not included in writing in the resident's plan of care.

Sources: interview with ADOC and a review of the resident's plan of care.