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 6, 2025

Inspection Number: 2025-1319-0005

Inspection Type:
Complaint
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): October 1-3, 6, 2025

The following intake(s) were inspected:

- Intake: #00157326 -2834-000030-25- Fall of resident resulting in injury with a change in condition
- Intake: #00157518 - 2834-000031-25 - Complaint/response - Complainant with concerns related to resident care
- Intake: #00157924 - PC-2025-0002839 - Complainant with concerns related to alleged resident-to-resident abuse.
- Intake: #00158909 - 2834-000033-25 - ARI - COVID - Outbreak Declared 26SEPT25 - 3rd Floor North

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

Skin and Wound Prevention and Management
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
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:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that a resident had written strategies, including interventions, to prevent, minimize, or respond to a resident's responsive behaviours. Specifically, the licensee has failed to ensure that a resident's specified monitoring intervention was included in the resident's plan of care as a written strategy for their responsive behaviours.

Sources:
Interviews with a Personal Support Worker (PSW), a Registered Practical Nurse

(RPN), and the Associate Director of Care (ADOC);
A resident's written and electronic chart;

The inspector reviewed the resident's care plan again and found the resident's monitoring intervention had been added as a written strategy for their responsive behaviours.

Date Remedy Implemented: October 2, 2025

WRITTEN NOTIFICATION: Policy to promote zero tolerance of abuse and neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Specifically, the licensee has failed to ensure that a resident had a skin and pain assessment performed and documented, after the resident made an allegation of physical abuse, as required by the home's policy OP-AM-6.9 Zero Tolerance of Abuse and Neglect of Residents.

Sources:

A resident's electronic chart;
Interviews with an RPN and ADOC;
Policy OP-AM-6.9 Zero Tolerance of Abuse and Neglect of Residents, last reviewed May 2025.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident at risk of altered skin integrity receives a skin assessment upon any return from hospital.

A resident returned from hospital on a specified date. An RPN stated in their interview that residents returning from hospital are to have head-to-toe skin assessments performed by a nurse as soon as they return. After record review with an RPN and the Director of Care (DOC), no documentation was found for a head-to-toe skin assessment on the resident until several weeks after their return to the home.

Sources:
A resident's electronic chart;
Record review with an RPN and the DOC;
Interview with an RPN.

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 the interventions developed for a resident's responsive behaviours were implemented to assist residents who are at risk of harm from a resident's behaviours. Specifically, the monitoring intervention for a resident's responsive behaviours was not fully implemented on a specified date. A PSW was assigned to a resident to monitor them. The PSW left the resident without any direct supervision and the resident began to wander into another resident room, placing the resident at risk of harm related to the resident's behaviours.

According to another PSW, an RPN and the ADOC, the assigned PSW for the resident's monitoring can never leave the resident alone due to their known responsive behaviours with other residents and staff.

Sources:
Interviews with a PSW, an RPN, and the ADOC;
A resident's plan of care;
A resident's electronic documentation.

WRITTEN NOTIFICATION: Infection prevention and control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement any standard issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee has failed to ensure that section 9.1 (b) of the IPAC Standard for Long-Term Care Homes, last revised September 2023, which requires hand hygiene practices at the four moments of hand hygiene which includes the performance of hand hygiene before initial resident/resident environment contact, was implemented.

During the inspection, the inspector observed a PSW interact with two residents in the 3rd Floor North hallway. The PSW was observed wearing the same pair of gloves and not performing hand hygiene between the interactions with each resident.

Sources:
Observation of a PSW;
Interviews with a PSW, an RPN, and the IPAC Lead.

The licensee has failed to implement any standard issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee has failed to ensure that section 10.2 (c) of the IPAC Standard for Long-Term Care Homes, last revised September 2023, which requires assistance to residents to

perform hand hygiene before meals and snacks, was implemented .

During the inspection, the inspector observed the lunch mealtime in the 3rd Floor North dining room. Two residents were observed coming into the dining room and being served fluids and snacks before the main meal service. No hand hygiene was observed being performed with either resident. The inspector spoke with one of the residents who stated that they had not received any hand hygiene prior to the meal commencing.

Sources:
Observation of two residents during meal time;
Interviews with a PSW and the IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participate in the implementation of the IPAC program. Specifically, the licensee has failed to ensure that a housekeeper removed their personal protective equipment (PPE) appropriately after interacting with the environment of a resident on contact and droplet precautions.

During the inspection, the inspector observed a housekeeper exiting a resident room which was on contact and droplet precautions at the time of the observation. The housekeeper was observed exiting the room with a gown and gloves on. The housekeeper proceeded to doff their gown and gloves in the hallway and dispose of the personal protective equipment (PPE) in the garbage on their housekeeping cart. According to the IPAC Lead, PPE from a resident on additional precautions must be doffed and disposed of in the resident's room in the designated garbage immediately prior to exiting the room.

Sources:
Observation of a housekeeper;
Interviews with a PSW, an RPN, and the IPAC Lead.

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a verbal complaint concerning the care of a resident and operation of the home was responded to in compliance with Ontario

Regulation 246/22 s. 108 (1) 3. within 10 business days of the receipt of the complaint.

Specifically, a resident did not receive a written response to their complaint related to an incident of alleged abuse from a co-resident. The home's policy OP-AM-6.3 Investigation Procedures states that complainants shall receive a letter that explains the outcome of the investigation and what action(s) have been taken to resolve the complaint.

Sources:
Interview with a resident;
Record review request from the ADOC;
The home's investigation notes into a resident's complaint;
Policy OP-AM-6.3 Investigation Procedures, last reviewed May 2025.