

**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:** December 23, 2025

**Inspection Number:** 2025-1319-0006

**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): December 17, 18, 19, 23, 2025

The following intake(s) were inspected:

- Intake: #00162879 (CI #2834-000042-25) - An incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in health status
- Intake: #00165053 - A complaint with concerns regarding consent for treatment, skin and wound care, falls and falls prevention interventions, and the home's environment.

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

Resident Care and Support Services  
Skin and Wound Prevention and Management  
Safe and Secure Home  
Falls Prevention and Management

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 5**

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Dining room serveries and steam tables on one floor were accessible to residents without supervision. The water in the steam tables reached temperatures up to 70.8 degrees Celsius.

Sources: Observation, temperature monitoring, interview with the Nutrition Services Manager.

### WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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.

A resident's plan of care identified the use of a fall prevention intervention. On one day, the resident's intervention was observed to be not in use.

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Sources: Care plan, observation, interview with a Personal Support Worker.