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

London District
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Public Report

Report Issue Date: April 17, 2025

Inspection Number: 2025-1178-0003

Inspection Type:
Complaint
Follow up

Licensee: Omni Quality Living (Lambton) Limited Partnership by its general partner, Omni Quality Living (Lambton) GP Ltd.

Long Term Care Home and City: Bear Creek Terrace, Petrolia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15, 16, & 17, 2025.

The following intake(s) were inspected:

- Intake: #00136198 - Follow-up CO #001, Inspection 2024-1178-0004, O. Reg. 246/22 - s. 35 (3) (a) Nursing and Personal Support Services relating to staffing plan, CDD March 21, 2025.
- Intake: #00142868 - Complaint related to care and services.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1178-0004 related to O. Reg. 246/22, s. 35 (3) (a)

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

Medication Management
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Records

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure a resident's clinical record was kept up to date.

Review of medication administration records (MARs) showed a number of instances where a resident's medication was not signed for and a few instances where the resident's medications were signed for but not actually administered.

A Registered Nurse (RN) stated they had charted incorrectly and had not actually administered the medications during a specific time period. The Director of Care (DOC) stated they had followed up with the staff about the other medication and it was indicated that they were either administered or refused and the staff forgot to document.

Sources: a Resident's clinical record, interview with the DOC and staff.