Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: November 3, 2023	
Inspection Number: 2023-1367-0004	
Inspection Type: Complaint Critical Incident	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Garden Terrace, Kanata	
Lead Inspector Saba Wardak (000732)	**Inspector Digital Signature**
Additional Inspector(s) Dee Colborne (000721) Pamela Finnikin (720492)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 26-27, 30, 2023.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake #00097805/ CI #2882-000036-23: related to alleged staff to resident physical abuse.
- Intake #00098617/ CI #2882-000037-23: related to medication management

The following intakes were completed in this complaint inspection:

- Intake #00098206: related to concerns about resident care and services

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

Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Residents' Rights and Choices

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. Specifically, the licensee failed to discontinue a medication for a resident as instructed by the prescriber.

Rationale and Summary:

A resident underwent a surgical procedure and returned to the home with specific instructions related to their medication.

ADOC confirmed that all post-operative instructions and prescriptions following a resident's return from the hospital should be reviewed by the receiving nurse and subsequently added to the resident's Medication Administration Record (MAR) or Treatment Administration Record (TAR) as required, after confirming this information with the resident's primary physician.

ADOC and registered staff confirmed that the specific instructions following the resident's surgical procedure were not transcribed to the resident's MAR and as a result, the medication was administered to the resident for an additional 30 days.

Although there was no actual harm to the resident, failing to ensure that the specific instructions were followed put the resident at a higher risk of harm.

Sources:

Resident's Electronic Medication Administration Record, Post-operative instructions sheet, interviews with ADOC and other staff.

[000732]