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
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Public Report

Report Issue Date: April 29, 2025
Inspection Number: 2025-1367-0003
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: Garden Terrace, Kanata

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22 - 25, 28, 29, 2025

The following intake(s) were inspected:

- Intake: #00144417 - Complaint related to the fall risk and the use of a restraint.
- Intake: #00144497/CI #2882-000021-25 - Related to concerns regarding the use of a restraint and a tilted wheelchair.
- Intake: #00144854/CI #2882-000022-25 - Related to a complaint regarding the improper/incompetent care of a resident and cleanliness of the room.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure that the monitoring of a physical device to restrain a resident, was documented. Specific to the use of a safety device when the resident is up in their wheelchair.

A review of the resident's Task Care Record documentation reflected several missing hourly entries on the day shift and on the evening shift on specific days in April 2025.

Sources: Physical Restraints and Personal Assistive Safety Devices policy (Policy # CS-5.2); resident's clinical record, interview with a PSW, a RPN, a RN and the DOC.