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: August 13, 2025
Inspection Number: 2025-1604-0003
Inspection Type: Critical Incident
Licensee: City of Ottawa
Long Term Care Home and City: Peter D. Clark Centre, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6, 7, 11, 2025.

The following Critical Incident (CI) intakes were inspected:

Intakes: #00152438 and #00152569 related to medication management.

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management system

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

Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that a member of the registered staff complied with the home's medication management program to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the medication management program were complied with.

On a specific date in July 2025, a member of the registered staff administered a resident's prescribed medication from another resident's supply. Furthermore, the registered staff member again failed to follow policy by not documenting the medication administration at the time it was given, resulting in errors in the medication reconciliation and tracking procedure.

Sources: Medication Administration policy, resident clinical records, home's internal investigation notes, and interviews with a registered nurse and the Manager of Resident Care.