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: August 8, 2025
Inspection Number: 2025-1241-0004
Inspection Type: Critical Incident
Licensee: Osgoode Care Centre
Long Term Care Home and City: Osgoode Care Centre, Metcalfe

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6-8, 2025

The following Critical incident (CI) intakes were inspected:

- Intake: #00149567/CI #2747-000006-25 related to a resident fall with injury
- Intake: #00153950/CI #2747-000007-25 related to a resident fall with injury

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee has failed to ensure that the long term actions planned to correct and prevent fall recurrence for a resident were documented in the Critical incident (CI) submitted on a specific date to the Director.

Sources: CI #2747-000006-25, Director of care interview

WRITTEN NOTIFICATION: Safe storage of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that a resident's prescribed medication was stored in a secure and locked location.

On two seperate days, the inspector observed a prescribed medication bottle on the resident's bedside table. The Director of Care (DOC) stated during an interview, that all prescription medication, were not to be kept at the bedside.

Sources: inspector observations, DOC interview