

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: January 15, 2025

Inspection Number: 2025-1319-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care
Limited Partnership

Long Term Care Home and City: Forest Hill, Kanata

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 2, 3, 6, 8, 9, 10, 13, 14, and 15, 2025.

The following intake was inspected:
Intake: #00135882 - Proactive Compliance Inspection

The following Inspection Protocols were used during this inspection:

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Food, Nutrition and Hydration
- Medication Management
- Residents' and Family Councils
- Safe and Secure Home
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Quality Improvement
- Staffing, Training and Care Standards

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

Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

Accommodation services

s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure the home, furnishings and equipment are kept clean and sanitary. Specifically, the home has failed to ensure a specified shower room floor was free of black particle build up. During an observation on a specified date, a moderate amount of black particle build up was noted on the perimeter of the floor in the shower room. During an interview with a resident, they confirmed that the black particle build up has been present for a significant amount of time.

Sources: Interview with a resident and an observation.

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

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

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff. Specifically, during the initial tour of the home the following doors to non-residential areas were found to be unlocked and unsupervised by staff:

- A treatment room door
- Three housekeeping room doors

A Registered Practical Nurse (RPN) and a Registered Nurse (RN) acknowledged that these doors should be locked when not being supervised by staff and locked these doors after being informed by the Inspector.

Sources: Initial tour observation, and interviews with RPN and RN.