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

# Original Public Report

**Report Issue Date:** February 14, 2024

**Inspection Number:** 2024-1367-0001

**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** | **Inspector Digital Signature** |
|---|---|
| Linda Harkins (126) | Linda Harkins Digitally signed by Linda Harkins Date: 2024.02.15 09:41:04 -05'00' |

**Additional Inspector(s)**
Lisa Cummings (756)

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 8, 9, 13, 14, 2024

The following intake(s) were inspected:

- Intake: #00101202, Critical Incident (CI) # 2882-000045-23 related to trust account
- Intake: #00104901, CI # 2882-000050-23 related to resident to resident physical abuse
- Intake: #00106625, CI # 2882-000004-24 related to a medication incident
- Intake: #00106740, complaint related to call bell response time and continence
- Intake: #00106870, CI # 2882-000005-24, allegation of improper/incompetent treatment related to plan of care regarding hygiene care and toileting schedule

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

Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Resident Charges and Trust Accounts

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Administration of drugs

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (2)**
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. Resident #005 was prescribed a medication on a specific date in 2024 and was never administered a dose until a substitution medication was ordered nine days later. No action was taken by the registered nursing staff until the substitution medication was ordered.

Sources: Interview with the Director of Care and health care record review.
[126]