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:** December 9, 2025

**Inspection Number:** 2025-1237-0007

**Inspection Type:**
Complaint
Critical Incident
Follow up

**Licensee:** Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.

**Long Term Care Home and City:** Woodland Villa, Long Sault

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 18, 19, 20, 21, 24, 25, 26, 27, 28, 2025 and December 1, 2, 4, and 8, 2025

The inspection occurred offsite on the following date(s): November 19, 2025

The following intake(s) were inspected:

- Intake: #00156935 - eCorrespondence - Complainant with concerns related to an resident related to bathing.
- Intake: #00158990 - AH-2025-0003301/2743-000049-25: Controlled substances missing/unaccounted involving an identified staff member.
- Intake: #00160418 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 3. 2025-1237-0006_CO#001 , Bowel Program-Assessments, CDD 12/5/2025
- Intake: #00160420 - Follow-up #1 - CO #003 / 2025-1237-0006, O. Reg. 246/22 - s. 147 (2) (a) Medication incidents and adverse drug reactions, CDD 12/5/2025.

- Intake: #00161575 - 2743-000053-25 - Injury to a resident of unknown etiology resulting in a fractured left hip requiring surgery.
- Intake: #00161937 - PC-2025-0004730 - Complainant with concerns regarding an identified resident alleging neglect leading to decline in health.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1237-0006 related to O. Reg. 246/22, s. 53 (1) 3.
Order #003 from Inspection #2025-1237-0006 related to O. Reg. 246/22, s. 147 (2) (a)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Housekeeping, Laundry and Maintenance Services
Reporting and Complaints
Pain Management
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

In resident #007's plan of care, an order was written on a date in the month of September, 2025, to have a specimen obtained for a specific test. The registered staff didn't comply with the plan of care for two weeks when the specimen was obtained on a date in October, 2025.

Sources: A specific resident's health records, interviews with staff.

## WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The plan of care documents the turning and re-positioning of a specific resident every two hours when they are in bed. A review of the resident's Point of Care (POC) documentation reflected missing entries on five shifts in the month of November 2025.

Sources: A specific resident's health records, and interviews with staff.

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 40**
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On a date in the month of October, 2025, a resident sustained an unwitnessed fall. Staff did not use safe transferring techniques when they assisted the resident off the ground without using a mechanical lifting device.

Sources: Home's investigation notes, interviews with staff, Policy #CS-6.2 Mandatory Lift and Transfer Procedures.

## WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 54 (2)**
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

On a date in the month of October, 2025, an identified resident sustained a fall and registered staff did not complete a post fall assessment using a clinically

appropriate assessment instrument specifically designed for falls.

Sources: A specific resident's clinical record, home's investigation notes, and interview with Director of Care.

## WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.**
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

On a date in the month of October, 2025, a resident's family made a verbal complaint to the DOC with concerns related to the resident sustaining an injury after an undocumented fall. The home did not provide a written response to the complainant within 10 business days.

Sources: Interview with DOC, and Policy #OP-AM-6.1 Investigating and Responding to complaints.

## WRITTEN NOTIFICATION: Drug destruction and disposal

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.**
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

In accordance with O.Reg 246/22, s.11(1)b, the licensee of a long-term care home shall institute any plan or policy that must be complied with and all applicable requirements under the Act. Upon review of the home's policy regarding destruction and storage of narcotics and controlled substances, it was identified that staff were not following the home's policy for the storage and destruction of narcotics.

The licensee did not ensure that controlled substances to be destroyed and disposed of are stored in a double locked storage area within the home. Specifically, on a date in the month of September, 2025, a registered staff member, removed a cassette with a specific quantity of controlled substance from an identified resident's, medication delivery device, and did not place it in a one-way access double locked box until it was destroyed. As a result, the medication was unaccounted for, and not located.

Review of the home's policy, CareRx, Policy and Procedure Manual, policy no: 7.7, Destruction and Disposal of Narcotic and Controlled Medications, states, "Any Narcotic or Controlled substance placed for disposal are stored in a "one-way access" double locked box, separate from any medication available for administration to a resident, until destroyed by the team physician or pharmacist

and a nursing staff designate."

Sources: critical incident, home's investigation notes, review of specific resident's electronic and paper health records, Combined Narcotic/Controlled Medication Count Record, CareRx Policy and Procedure Manual, revised Jul 31, 2025, no: 7.7, Destruction and Disposal of Narcotic and Controlled Medications, interviews with staff.

## COMPLIANCE ORDER CO #001 Falls prevention and management

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 54 (1)**
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

A) Develop and implement an audit tool that will be used to ensure that all steps of the home's policy: Resident falls and Post fall assessment are being followed, and all documentation is being completed. Audit all falls on the identified unit for four weeks for staff compliance with home's policy. All audits must include at minimum: resident's name and date of fall, staff compliance with steps of home's policy, staff

member that conducted the audit, date the audit was completed and any findings of the audit.

B) If staff knowledge gaps are identified as a result of the audits, provide re-education or training to applicable staff on the home's Falls Management program, or any other relevant policies or procedures if applicable. For any re-education or training that was completed, keep records that include the contents reviewed, date and time of review, name of staff that provided re-education, and name of staff receiving re-education including their signatures of completion.

C) Maintain a record of everything required under part A) and part B) and retain all records until the MLTC has deemed that this order has been complied with.

Grounds

On a date in the month of October, 2025, an identified resident sustained an unwitnessed fall and staff members did not comply with the home's policy Resident Falls and Post Fall Assessment, #OTP-FP-7.4. As per O. Reg 246/22 s. 11 (1) b., the home must have a falls prevention and management program, and that program must be complied with.

The home's Policy: Resident Falls and Post fall assessment #OTP-FP-7.4. Last approved date: July 3, 2025 states the following:

-Resident shall be made comfortable but not moved until they have been assessed by registered staff for pain, dislocation, fractures, LOC.
-When safe to do so, resident is to be moved using mechanical lift.
-Registered staff exam should include (skin condition, vital signs, pupil reaction).
-Head injury routine (HIR) shall be initiated for any unwitnessed fall.

-HIR will continue for 72 hours in intervals required as per Neurological Vitals Signs Post Head Injury Form.
-Appropriate actions are be to taken immediately based on assessment.
-Registered staff shall initiate post fall huddle.
-Notify physician.
-Notify POA.
-Incident shall be communicated at next shift report.
-Documentation of the fall shall be initiated by entering the risk management section.
-Initiate post fall assessment and complete all required sections.
-Complete progress note with requirements.
-Follow up documentation for 72 hours post fall.
-Plan of care to be updated.

Specifically, after the identified resident sustained an unwitnessed fall on a date in the month of October, 2025, and staff members did not follow multiple steps of the home's policy. Review of resident's clinical record did not show any record of an assessment being completed by registered staff that included assessment for pain, dislocation, fractures and level of consciousness prior to staff moving the resident. During interviews with staff it was confirmed they did not use the mechanical lifting device to assist the resident off the ground. Record review did not indicate any record that staff completed a full head to toe assessment that included (skin condition, vital signs, pupil reaction, pain, mobility of limbs and range of motion). Record review did not indicate any record that the head injury routine was initiated as required for an unwitnessed fall, and as a result it was not continued for the 72 hours in the intervals required as per Neurological Vitals Signs Post Head Injury Form. Record review did not indicate any record that registered staff initiated a post fall huddle with other staff members. Review of the resident's progress notes did not indicate that the physician was called at time of fall, documentation indicated a

note was left in the physician binder on a date in the month of October, 2025. The physician assessed the resident three days later for increased pain. During an interview with the identified resident and their Substitute Decision Maker (SDM), stated they were never notified about the fall, and they initially brought concerns forward to the home because the resident kept stating they had fallen. Review of the resident's clinical record and shift report binder indicated that resident's fall was never reported during shift report, and as a result subsequent shifts were not aware that resident had sustained an unwitnessed fall on the evening of a specific date in the month of October, 2025. Review of the resident's clinical record for the fall sustained on this date, did not indicate any post fall assessment were completed at time of incident, and no documentation or follow up documentation related to fall completed by any registered staff. Review of resident's plan of care indicated that resident's fall prevention and management intervention were updated on a date in the month of November, 2025. During an interview with the DOC, it was confirmed that the staff members did not follow the home's policy and none of the required assessments or documentation was completed in Point Click Care (PCC).

Sources: Policy: Resident Falls and Post fall assessment #OTP-FP-7.4. Last approved date: July 3, 2025, a specific resident's clinical record, shift report binder, and interviews with the resident, SDM, and staff.

This order must be complied with by March 2, 2026.

## COMPLIANCE ORDER CO #002 Skin and wound care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

A) Update any relevant skin and wound management policy and procedures to ensure that they outline the specific roles and responsibilities for all registered staff related to the home's skin and wound management program. They must provide clear direction for registered staff in the event that a new or worsening skin impairment is reported, to the appropriate individuals when identified staff members are away.

The policy and procedures must include but is not limited to the following:

-how to complete an initial skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment when any resident is exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds.
-how to determine the initial treatment plan so that the resident receives immediate treatment and intervention to reduce or relieve pain, promote healing, and prevent

infection.
-how to input the treatment plan into the resident's treatment administration record (TAR) so that any subsequent treatment is completed on time.
-how to ensure that each resident exhibiting altered skin integrity is reassessed at least weekly if clinically indicated.
-how each new finding is to be reported to the appropriate individuals as applicable.
-in the event that the delegated wound registered staff member is absent and there are treatments or skin assessments to be completed, who will be responsible for completing these tasks and how will this be communicated to them.
-the expectation for the delegated staff member to check the skin and wound communication binder on each unit frequently, and a process that includes initials and date to confirm that any new skin impairment has been acknowledged.
-the expectation for registered staff related to the documentation of the above.

B) Educate all registered staff on the policy and procedures updated in part A) and the requirements outlined in O. Reg. 246/22, s. 55 2 (b)- skin and wound care. For all education that was completed, keep records that include the contents reviewed, date and time of review, name of staff that provided education, and name of staff receiving education including their signatures of completion.

C) Audit one resident on each home area that is exhibiting altered skin integrity to ensure that weekly assessments and all ordered treatments are being performed and documented according to the home's policy and procedure. If staff knowledge gaps are identified as a result of the audits, provide re-education or training to applicable staff on the home's skin and wound program, or any other relevant policies or procedures if applicable. For any re-education or training that was completed, keep records that include the contents reviewed, date and time of review, name of staff that provided re-education, and name of staff receiving re-

education including their signatures of completion.

D) Maintain a record of everything required under part A) B) and C) and retain all records until the MLTC has deemed that this order has been complied with.

**Grounds**

**Skin assessment**

During the evening on a date in the month of October, 2025, an identified resident sustained an unwitnessed fall and their skin condition was not assessed by registered staff as required by the home's policy: Resident falls and Post fall assessment #OTP-FP-7.4 last reviewed on July 2025. According to the home's investigation notes, later that same night a staff member identified that the resident was found to have altered skin integrity. According to the home's investigation notes, the staff reported the findings, but record review did not show a skin assessment being completed by the registered staff at this time. The following day, it was documented that a dressing was in place and intact. However, the dressing was not removed to complete a full skin assessment. The resident's skin was not assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

**Immediate treatment**

After the skin impairment on the resident was reported on a date in the month of October, 2025, the resident did not receive any immediate treatment or interventions to promote healing and to prevent infection. A review of the clinical record, for a specific date in the month of October indicated a dressing was later in place but did not show any documentation of any immediate treatment completed. Interview with a specific staff member, indicated that the skin impairment was never reported to them, and they were unaware of when or who removed the dressing. Review of resident's treatment administration record (TAR)

and clinical records did not indicate any treatment plan or subsequent treatments completed on the skin impairment after a specific date in the month of October, 2025.
On a date in the month of November, 2025, the resident's clinical record had specific instructions for registered staff to perform regarding a skin impairment that was to be completed two days later. This was completed ten days after it was supposed to be done. Interview with a registered staff member and record review of the resident's clinical health record, did not indicate any treatment plan or subsequent treatment between specific dates in the month of November 2025.

Reassessment
Review of the identified resident's clinical record did not show any record that their skin impairment was assessed or reassessed by registered staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. The treatment plan for the skin impairment was not entered into the resident's TAR or reported and as a result, no subsequent treatments or reassessments was completed by the registered staff.

Review of the resident's clinical record and during an interview with a staff member it was confirmed that a skin assessment was completed on a date in the month of November, 2025, and fourteen days later, and was not completed at minimum at least weekly, when it was clinically indicated. The treatment plan for the skin impairment was not entered into resident's TAR and as a result, no subsequent treatments or reassessments was completed by the registered staff.

Sources: A specific resident's clinical record including point of care (POC), treatment administration records (TAR), progress notes, skin and wound assessments, hospital discharge orders, home's investigation notes, interviews with staff, and Policy: Resident Falls and Post fall assessment #OTP-FP-7.4. Last approved date: July 3,

2025.
**This order must be complied with by** March 2, 2026.

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Compliance Order CO #002**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**

Skin and wound care

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after

service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## COMPLIANCE ORDER CO #003 Pain management

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 57 (2)**
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

A) Educate all registered staff on the expectation of how and when to complete the clinically appropriate pain assessment tool, when to reassess the resident, and what actions to take when a resident is experiencing uncontrolled pain and pain is not relieved by initial interventions.

B) For all education that was completed, keep records that include the contents reviewed, date and time of review, name of staff that provided education, and name of staff receiving education, including their signatures of completion.

**Grounds**

On a date in the month of October, 2025, an identified resident sustained an unwitnessed fall and was not assessed for pain using a clinically appropriate tool specifically designed for pain management at time of the fall. Later that same day, a staff member reported that the resident was in pain and no pain assessment was completed. The following day, it was documented that staff reported the resident was experiencing pain and the medication given was ineffective, no pain assessment was completed. On another date in the month of October, 2025, a registered staff member documented that the resident was complaining of pain, no pain assessment was completed. On this same date it was later documented that as required medication was administered to the identified resident and was ineffective. According to the home's pain assessment policy, staff are to contact the primary physician when a resident's pain is not relieved by initial interventions and this was not completed by multiple staff on different days.

Sources: Home's investigation notes, a specific resident's clinical record, home's policy: Pain Assessment #OTP-PM-5.3 last approved March 6, 2025 and interviews with staff.

**This order must be complied with by** March 2, 2026.

## COMPLIANCE ORDER CO #004 Medication management system

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

Educate an identified registered staff member, on the home's policies and procedures for safe administration of medications. And review the College of Nurses of Ontario (CNO) Medication Practice Standard.

Educate all registered staff on CareRx Policy and Procedure Manual, policy no: 5.10, and no: 7.5.

Educate all registered staff working on a specific unit with an identified resident, how to properly complete the medication delivery device flow sheet, and the expectation for two registered staff members to physically witness the delivery device to verify the total remaining quantity of narcotic medication remaining.

Educate the identified staff members how to use the medication delivery device to ensure they can obtain this information from the device. Verify staff understanding by ensuring they are able to physically demonstrate this task.

Develop and implement an audit tool to audit on the proper completion of individual resident combined narcotic/controlled medication count records, shift change narcotic/controlled medication records, and the completion of the identified resident's, medication delivery device flow sheet. As well, auditing medication carts to ensure no pre-pouring of narcotic/controlled medications, and/or storing of opened ampoules of narcotics/controlled medications for future administration.

Complete three audits per week, using the developed audit tool, on each home area at different times of day to ensure staff compliance, for a period of four weeks. Take corrective action for any identified non-compliance.

Keep a written record of the education provided including but not limited to, the person providing the education, date education provided, identified staff educated, and the education content provided. And anything else related to items one through five. All records must be kept until this order is complied.

**Grounds**

In accordance with O.Reg 246/22, s.11(1)b, the licensee is required to ensure their written policies and procedures ensure their accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. Upon review of the home's policies regarding medication administration and documentation, Combined Narcotic/Control Count Record, and shift change Narcotic/Controlled Medication Count Record of narcotics and controlled substances, it was identified that staff were not following the home's policies for the administration and documentation of narcotics and controlled substances.

The home's policies, CareRx, Policy and Procedure Manual;
Documentation of Narcotic and Controlled Medication Counts, policy, No: 7.5, states;
- "when administering the Narcotic/Controlled medication, nurse documents for the administration of the medication on the resident's MAR and on the Combined Narcotic/Controlled Medication Count Record."
- "sign on the Combined Narcotic/Controlled Medication Count Record each time a dose is administered. Include the date, time, amount given, amount wasted, and quantity remaining on hand. Another nurse is required to witness and sign for wasted amounts of Narcotic/Controlled medications when applicable."
- "Two nursing staff (outgoing and incoming) together:
a) count the actual quantity of medication on hand;
b) confirm quantity on hand is the same as the amount recorded on the Resident Narcotic/Controlled Medication Count Record and packaging/product integrity is intact.
c) record the details as outlined in the form including: date, time, quantity of medication and sign in the appropriate spaces on the Shift Change Narcotic/Controlled Medication Count Record.
d) Report immediately any discrepancies to the Nurse Manager, Director of Care (or designate) for further investigations."
Administration of Injectable Medications, policy, No: 5.10, states;

- "Discard the remaining quantity of medication in the ampoule following medication destruction procedures. A witness is needed for wasting of Narcotic and Controlled medications."
- "Do not save residual medication for subsequent injections unless explicitly directed by administrative staff and/or the manufacturer. The storage of opened ampoules with residual medication is not acceptable."

Specifically, on a date in the month of September, 2025, an identified staff member, wasted a specific quantity of a resident's narcotic medication, without another registered staff member to witness and document the wasted medication. Further review of the resident's medication delivery device flow sheet records shows that on a date in the month of October, 2025, another registered staff member, wasted a quantity of narcotic medication, without a second nurse to witness and sign the medication wastage.

On a date in the month of September, 2025, a staff member, did not document on an identified resident's, electronic medication administration record (EMAR), or on the combined narcotic/controlled medication count record, the administration of prescribed medication, as a result the narcotic medication was unaccounted for. On the same day, the staff member, did not document on another resident's, EMAR, or combined narcotic/controlled medication count record for the administration of a controlled substance, which was also unaccounted for on this date.

On a date in the month of November, 2025, an inspector observed on a specific unit, medication room, that an identified registered staff member, had pre poured narcotic and controlled substances for five resident's, and signed on the residents individual combined narcotic/controlled medication records that were prescribed to be administered later that day. At the time of observation the identified staff member confirmed that this practice was not according to the home's policy.

This same day, an inspector observed on a different unit, medication room, an opened ampoule of a controlled substance, interview with an identified staff member, informed the inspector that they had administered the medication to a specific resident, and were keeping the opened ampoule of medication for the entirety of the shift to administer any other required as needed doses to the resident, and would waste any unused medication at the end of the shift. It was also noted at this time that the staff member, did not document the administration of the medication on the combined narcotic/controlled medication count record for this specific resident. The staff member was unaware if this observed practice was according to the home's policy.

Later, this same day the inspector observed on another unit, medication room that a registered staff member, administered controlled substances to three resident's without signing any of the identified residents combined narcotic/controlled medication count records.
It was also noted on this date in November, 2025, that none of the shift change narcotic/controlled medication count records on all units were signed by the incoming registered staff confirming the accuracy of the shift counts for the narcotics and controlled medications stored on the respective units.

All observations made on the date in the month of November, 2025, were confirmed by the DOC, when the inspector brought them to each respective unit to validate the accuracy of the observations that were made.

Record review of an identified resident's, medication delivery device flow sheet revealed that there were multiple missing shift entries in the month of September, October, and November 2025, for the verification of the total remaining narcotic medication for each shift. As well, there were multiple missing entries of incoming and outgoing registered staff signatures to verify the accuracy of the remaining

drug. As a result, it is difficult to determine the accuracy of the total drug counts for this identified resident. Interview with a staff member, indicates that it is not common practice for outgoing and incoming registered staff to verify the accuracy of the count for the remaining narcotic medication in the resident's medication delivery device. They indicate that they would verify the count on the device later in the shift and that if the count was accurate, they would co-sign the flow sheet. Interview with DOC, confirmed that on reviewing the resident's, medication delivery device flow sheet that there were multiple missing shift entries as well as missing signatures of registered staff outgoing and incoming to verify the quantity of the narcotic drug remaining.

Sources: record review of critical incident, home's investigation notes, electronic and paper health records for identified residents', resident narcotic/controlled medication count records, and shift change narcotic/controlled medication count records, CareRx Policy and Procedure Manual, policy no: 5.10, and policy no: 7.5, observations made on resident units with DOC, and interviews with staff.

**This order must be complied with by** March 2, 2026.

## COMPLIANCE ORDER CO #005 Safe storage of drugs

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

Obtain a double locked box(es) to store narcotics/controlled substances that require refrigeration within the medication refrigerator(s). And/or obtain a locked box(es) to store narcotics/controlled substances within a medication refrigerator(s) that is equipped with an external lock, that will store narcotics/controlled substances that require refrigeration. Review with all registered staff, the implementation of this new procedure within the home, including how and when, which keys to use with respect to utilizing the double locked/locked box(es) to store narcotics/controlled in medication refrigerator(s) with or without external locking features.

Educate all registered staff on Ontario Regulation (O.Reg) 246/22, s.138(1)(b)- safe storage of drugs. As well, as the home's policies for storage of Narcotics and Controlled medications.

Develop and implement an audit tool to audit the safe storage of narcotics/controlled substances for both the medication carts and any medication refrigerator that stores narcotics/controlled substances.

Complete one audit per week per each home area at different times of day to ensure staff compliance with the safe storage of narcotics/controlled substances in medication carts and any refrigerator used to store narcotics/controlled substances for a period of four weeks. Take corrective action for any identified non-compliance with the safe storage of narcotics/controlled substances.

Keep a written record of the education provided including but not limited to, the person providing the education, date of education provided, identified staff educated, and the education content provided. And anything else related to items one through four listed in this order. All records must be kept until this order is complied.

Grounds:

The licensee did not ensure that all narcotics and controlled substances are kept double locked while being stored. Specifically, observations on a resident unit on a date in the month of November, 2025, when a staff member, had pre-poured narcotics and controlled substances for five different resident's. These medications were prescribed to be administered several hours later, which were placed in clear unlabeled medication cups sitting in the drawers of the medication cart, not double locked.

Later that same day on another resident unit, an opened ampoule of narcotic medication, prescribed for an identified resident, was sitting in a clear medication cup, in the drawer of the medication cart not double locked. The home's policy, CareRx Policy and Procedure Manual, policy no: 7.3, Storage of Narcotic and Controlled Medications, revised July 31, 2025, states " All Narcotic and Controlled medications must be kept in the locked box located in the designated drawer of the medication cart or in a separate, double locked stationary cupboard in the locked medication room. Narcotic and Controlled medication storage areas must remain locked at all times."

On a different date in the month of November, 2025, in the medication room of a resident unit, an observation was made of a specific resident's, prescribed narcotic medication stored in a single locked refrigerator, not in a double locked box. The home's policy, CareRx, Policy and Procedure Manual, policy no: 7.3, Storage of Narcotic and Controlled Medications, revised July 31, 2025, states "Narcotic and Controlled substances requiring refrigeration must be stored with a double locked box within the refrigerator."

On a date in the month of September, 2025, the Director was notified on discovery that a quantity of prescribed narcotic medication was unaccounted for a specific resident, after it was replaced by a staff member, despite previous medication still

available to be administered. During interviews conducted with staff it was determined at the time of this incident the medication fridge on specific unit, used to store the identified resident's narcotic medication was never locked, and that staff were not aware of any key to be used to lock the refrigerator. As well, registered staff also indicate that all unit registered staff keys open all other medication rooms on other home units within the home.

Sources: record review of critical incident, home's investigation notes, residents electronic and paper health records for identified residents, Combined Narcotic/Controlled Medication Count Records, Shift Change Narcotic/Controlled Medication Count Records, CareRx Policy and Procedure Manual, no: 7.3 and 7.5, observations made on resident unit medication rooms, medication carts and medication refrigerator with DOC #103, and interviews with staff and DOC.

**This order must be complied with by** March 2, 2026.

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.