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 1, 2024

Inspection Number: 2024-1488-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Centre d'Accueil Roger Seguin

Long Term Care Home and City: Centre d'Accueil Roger Seguin, Clarence Creek

Lead Inspector	**Inspector Digital Signature**
Linda Harkins (126)	Linda Harkins Digitally signed by Linda Harkins Date: 2024.02.01 10:09:10 -05'00'

Additional Inspector(s)
Lisa Cummings (756)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23, 24, 25, 29, 30, 31, 2024
The inspection occurred offsite on the following date(s): January 26, 2024

The following intake(s) were inspected:

- Intake #00100616: Complaint related to call bell response time
- Intake #00104242: Critical Incident (CI) #2988-000049-23 related to falls
- Intake #00105865: CI #2988-000002-24 allegation staff to resident abuse
- Intake #00105931: Complaint related to cleanliness of home, Infection Prevention And Control (IPAC), laundry, continence, nutrition and hydration and resident care and services

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The following intake #00102749, CI #2988-000046-23 related to falls was completed.

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

Resident Care and Support Services
Continence Care
Housekeeping, Laundry and Maintenance Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff

that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of neglect was reported immediately to the DIrector. The Administrator and a Director of Care (DOC) became aware of an allegation of neglect and notified the Director ten days later.

Source: Interview with DOC and a Critical Incident.
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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 the medication cart was locked. On a specific day, a medication cart was observed to be left unattended and unlocked in the dining room while residents were waiting for their meals to be served.

Sources: Observation and interview with a Registered Practical Nurse (RPN).
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