



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**
**Division des foyers de soins de
longue durée**
Inspection de soins de longue durée

Ottawa Service Area Office
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**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 3, 2016	2016_286547_0031	020721-16, 027361-16	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

MONTFORT
705 Montreal Road OTTAWA ON K1K 0M9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 1-2, 2016

The purpose of this inspection was related to the following critical incidents the home submitted related to:

- Log #027361-16 regarding an incident of fall with injury/hospital transfer with significant change in status
- Log #020721-16 regarding a family written complaint provided to the home regarding personal care for a resident

During the course of the inspection, the inspector(s) spoke with residents, resident families, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Educator, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Executive Director.

At the time of the inspection, the inspector observed aspects of resident care and interactions with staff. The inspector reviewed resident health care files, including written plans of care and assessments. The inspector also reviewed the home's investigation documentation for associated critical incident inspections, reviewed the home's falls prevention program and the licensee's reporting and complaints procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

Reporting and Complaints

Responsive Behaviours

During the course of this inspection, Non-Compliances were not issued.

**0 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**



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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Legendé

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

Issued on this 3rd day of November, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs



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Original report signed by the inspector.