Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 23, 2020	2020_618211_0001	019492-19	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 7 and 8, 2020.

A complaint inspection, log #019492-19, was conducted related to alleged neglect of resident care due to an unknown incident.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RNs), several Personal Support Workers (PSWs), and a family member.

During the course of the inspection, the inspector reviewed resident health care records, Medication Administration Records, Personal Assistance Services Device (PASD) consent, Physiotherapy Report forms, Westminster Mobile Medical Imaging reports, Pain Control sheets, Fall Risk Assessments, Fall Risk Screen, Post-Fall Assessments, Neurological Assessment sheet, Skin and Wound Assessment, Skin and Wound-total Body Skin Assessment, Multidisciplinary Conference Form, Behavioural Support Ontario-Dementia Observation System, Staff Schedule and Skin and Wound's policy.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Review of resident #001's progress notes indicated that the resident had a fall on an identified date during a specific shift and sustained an injury to an identified body area. The resident was sent to the hospital for treatment. The resident returned from the hospital on the same date during a specific shift.

Review of resident #001's health care record doesn't demonstrate that a skin assessment was performed when the resident returned from the hospital.

In an interview with ADOC on an identified date, stated that their Skin and Wound Policy indicated that a skin assessment was required if the resident was returning from a hospital stay more than twenty-four hours.

The licensee has failed to ensure that resident #001 received a skin assessment by a member of the registered nursing staff upon returning from the hospital on the identified date. [s. 50. (2) (a) (ii)]

Issued on this 24th day of January, 2020

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

Original report signed by the inspector.