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
Mar 3, 2022	2022_966755_0003	000617-22	Critical Incident System

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

MANON NIGHBOR (755)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 8-11, 2022.

The following intake was completed as part of the Critical Incident System (CIS) Inspection:
Log #000617-22, (CIS) #2886-0000-01-22 related to resident to resident physical responsive behaviour.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs).

The inspector reviewed related healthcare records, directives for the Behavioural Supports Ontario-Dementia Observation System data collection form (BSO-DOS), "Bilan Neurologique" (neurological assessment tool), "Fiche de Contrôle de la Douleur" (pain assessment tool), made observations of the provision of resident care and services, staff and resident interactions and conducted interviews with staff.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's pain, behaviours and neurological assessments were documented as set out in their plan of care.

The resident was involved in a resident to resident responsive behaviour altercation, subsequently they fell and sustained injuries.

As per the home's post fall protocol, a neurological assessment tool was initiated. A pain assessment tool was also initiated upon the onset of resident's new pain and a Behavioural Supports Ontario-Dementia Observation System data collection form (BSO-DOS) form was initiated upon resident's responsive behaviour. Their purpose is to assess, observe, control, monitor and, analyze resident post incident.

A neurological assessment tool was not completed. Six out of 19 entries were missed. When resident sustained another fall under different circumstances. Another neurological assessment tool was initiated and four entries were incomplete.

A pain assessment tool was initiated and six shifts were missing out of the 12 entries required.

A BSO-DOS data collection form was initiated, the form was not found in resident's health record. Two staff members could not locate it. The observation period continued and the next two forms were incomplete. One was missing six shifts and the following one had five shifts left blank. Step 1 which identifies the reason why the form was initiated and step 3 which analyses the data were also not completed.

The required assessments were not documented as per the home's pain, behaviour and post fall procedures. The lack of documented monitoring, assessments and observations paused a potential risk of not identifying a change in the resident's condition, post incident.

Sources:
Behavioural Supports Ontario-Dementia Observation System data collection forms (BSO-DOSs).
Pain assessment tool, Fiche de Contrôle de la Douleur forms.
Neurological assessment tool, Bilan Neurologique forms.
Interviews with three staff members.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision, outcomes and effectiveness of the care set out in the plan of care are documented, to be implemented voluntarily.

Issued on this 4th day of March, 2022

[redacted]

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

Original report signed by the inspector.