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: July 27, 2023

Inspection Number: 2023-1371-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Montfort, Ottawa

Lead Inspector	**Inspector Digital Signature**
Linda Harkins (126)	Linda Harkins Digitally signed by Linda Harkins Date: 2023.07.28 10:32:29 -04'00'

Additional Inspector(s)
Lisa Kluke (000725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11, 19, 20, 21, 24, 25, 26, 2023
The inspection occurred offsite on the following date(s): July 19, 25, 2023

The following intake(s) were inspected:

- Intake: #00001964, Intake: #00005504, and Intake: #00022379 related to resident falls.
- Intake: #00002791 complaint related to multiple care concerns.
- Intake: #00004992 related to alleged staff to resident abuse.
- Intake: #00018256 related to resident to resident abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Police Notification

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Rational & Summary
The licensee reported a Critical Incident Report for resident to resident abuse. This report documented that no additional authorities such as police service were informed.

A Registered Practical Nurse (RPN) indicated to inspector #126 that the police service was not informed immediately of this incident.

As such, no appropriate police force was immediately informed of this resident to resident abuse as required.

Sources: Resident record review, interview with an RPN. [126]

The licensee has failed to ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse of another resident, that the licensee suspected may constitute a criminal offence.

Rationale/Summary
The licensee reported a Critical Incident Report for an alleged incident of staff to resident abuse. This report documented that additional authorities were informed as N/A meaning non-applicable.

The Directrice Generale (DG) indicated to inspector #000725 that based on their review of this investigation, the police service was not informed of this incident.

As such, no appropriate police force was immediately informed of this alleged staff to resident abuse as required.

Sources: Resident record review, interview with DG. [000725]

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