

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 25, 2024	
Original Report Issue Date: January 23, 2024	
Inspection Number: 2024-1371-0001 (A1)	
Inspection Type: Complaint	
Licensee: Santé Montfort	
Long Term Care Home and City: Montfort, Ottawa	
Amended By Manon Nighbor (755)	Inspector who Amended Digital Signature

AMENDED INSPECTION SUMMARY

This report has been amended to:
A non-compliance related to O.Reg s. 65 (b) therapy services has been cancelled considering new information provided by the licensee.

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Licensee: Santé Montfort	
Long Term Care Home and City: Montfort, Ottawa	
Lead Inspector Manon Nighbor (755)	Additional Inspector(s) N/A
Amended By Manon Nighbor (755)	Inspector who Amended Digital Signature

AMENDED INSPECTION SUMMARY

This report has been amended to:
A non-compliance related to O.Reg s. 65 (b) therapy services has been cancelled considering new information provided by the licensee.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4 and 5, 2024.

The following intake(s) were inspected:

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- Intake: #00103742 -Complaint related to nutrition and body position support needs.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

The licensee has failed to ensure that the Nutritional Care and Hydration programs include, weight on admission and monthly thereafter.

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Rationale and Summary:

The resident had nutritional swallowing risk due to their poor body position when sitting in their wheelchair at meals.

There was no weight record for the month of November, 2023. There was a significant weight loss noted between October and December, 2023's weight.

The Registered Dietitian (RD), staff member #106 stated that the resident was underweight, that their weight had not been measured for a month, that the resident's weight loss was noticeable and that eating was difficult for the resident.

A Registered Nurse (RN), staff member #108 confirmed they had measured the resident's weight in December, 2023, and noted the resident's weight loss. During this period of time they stated the resident was becoming drowsy.

The Environmental Service Manager (ESM), staff member #110 confirmed that they verified the scale's calibration, for this resident's weight measurement.

As such, not weighing the resident in November 2023 placed the resident's health at risk. The December's weight demonstrated the resident had lost a significant amount of their body weight since October, 2023. The family took the resident to their personal home for several weeks, where they regained their weight loss.

Sources:

Resident's related health records.

Interviews with staff members #106, #108 and #110.

[755]