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
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Original Public Report

Report Issue Date: August 16, 2024
Inspection Number: 2024-1371-0003
Inspection Type: Complaint Critical Incident
Licensee: Santé Montfort
Long Term Care Home and City: Montfort, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8, 9, 12, 13, 14, 15, 16, 2024

The following intake(s) were inspected:
Complaint

- Intake: #00118184 and #00119809 related to pain management
- Intake: #00121603 related to a resident's care plan.

Critical Incident System Report (CIS)

- Intake: #00119321 - CIS #2886-000008-24 related to alleged resident to resident abuse.
- Intake: #00120650 - CIS #2886-000010-24 related to alleged resident to resident abuse.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident's medication set out in the plan of care was administered to the resident as specified in the plan.

Sources: Resident's Progress Notes, and electronic medical administration record (eMAR). Interviews with staff members.

WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's

pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by a medication, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Sources: Progress Notes, eMAR, Point Click Care (PCC) assessment record, and the resident's paper chart. Interviews with staff members.

WRITTEN NOTIFICATION: Evaluation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 106 (a)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

A- The licensee has failed to ensure that an analysis of an alleged abuse of a resident by another resident, which resulted in an injury, was undertaken promptly after the licensee became aware of it.

Sources: Behaviours Support Ontario-Dementia Observation System (BSO-DOS). Interview with a staff member.

B- The licensee has failed to ensure that an analysis of an alleged abuse of a second resident by another resident was undertaken promptly after the licensee became aware of it.

Sources: BSO-DOS, Outil d'Evaluation des Comportements Reactifs. Interview with a staff member.