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

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Public Report

Report Issue Date: February 3, 2025
Inspection Number: 2025-1371-0001
Inspection Type: Critical Incident
Licensee: Santé Montfort
Long Term Care Home and City: Montfort, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 27, 28, 29, 30, 2025

The following intake(s) were inspected:

- Intake: #00135131 (CIS #2886-000022-24) related to a fall of a resident resulting in an injury.
- Intake: #00136747 (CIS #2886-000003-25) related to injury to a resident with unknown cause.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A- The licensee has failed to ensure that for a resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A resident's displayed specified behaviours, the intervention was to keep the resident busy by allowing them to complete identified tasks unsupervised. On an identified date, the resident complained of pain and further had a specified injury.

On a day in January 2025, the resident was observed exhibiting the specified responsive behaviours within the home area. The resident 's care plan did not identify reassessment or the responses the above interventions.

Sources: Inspector's observation. Review of resident's progress notes, plan of care, and critical incident report (CIS). Interviews wit staff members.

B- The licensee has failed to ensure that for a resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including reassessments and that the resident's responses to interventions were documented.

Review of the resident health records, showed that on an identified date in 2024, during evening and night shifts, a resident refused care and exhibited identified responsive behaviours. An identified intervention was implemented. The resident reported to a staff member that they were pain, which was assesses as an injury. Further review did not identify reassessment or the responses to one-on-one interventions.

A staff member indicated that assessment tool should have been initiated and documented when the one-on-one staff was assigned to the resident. Another staff member acknowledged that they had not reassessed the resident.

Sources: Review of resident's health record, (assessment record, progress notes, and plan of care, Document Survey Report) Interviews with staff members.

WRITTEN NOTIFICATION: IPAC

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The licensee has failed to implement the appropriate selection of Personal Protective Equipment (PPE) when providing direct resident care on additional precautions.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2022, section 9.1(f) states at minimum, Additional Precautions shall include appropriate selection application, removal, and disposal of PPE.

On an identified day in 2025, an additional precaution sign was posted at a resident's door, directing staff to wear gloves and gown for direct care.
On the same day at a staff member was observed providing continence care to the resident. The staff member had not wore a gown during care.

Sources: Inspector's observations, Review of resident's plan of care and Additional contact precaution sign. Interviews with staff members.