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: June 13, 2025
Inspection Number: 2025-1371-0003
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): June 3-6, 9-13, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00146296/CI# 886-000015-25 related to alleged neglect of a resident by staff.
- Intake: #00146771/CI# 2886-000016-25 related of alleged neglect of resident by staff.
- Intake: #00147244/CI# 2886-000019-25 related to missing resident.
- Intake: #00147764/CI# 2886-000021-25 related to missing resident.

The following complaint intake(s) were inspected:

- Intake: #00148451: complainant related to concerns regarding resident physical/financial abuse, medication management, resident-staff communication and response system.

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

Resident Care and Support Services
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee has failed to ensure that a resident rights were fully respected and promoted related to giving or refusing consent to mail services for which their consent is required by law.
A resident reported having received two pieces of mail since their admission in the home, and they were upset these were opened without their consent. A staff member indicated they opened the residents mail that was addressed to the resident before receiving the resident's consent.

Sources: Resident and family interviews; observation of a letter received in the home by mail addressed to a resident that was opened; interview with staff, the resident and a family member.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A resident was known to leave the Long Term Care Home (LTCH) to attend nearby community locations. Despite missing several care and services, the LTCH staff remained unaware of the resident's absence from the home and made no attempt to locate the resident as their plan of care contained no direction related to the resident's routine activities outside the home. When on the next day it was discovered that the resident was missing, it was determined that the resident had received medical attention while in the community.

Sources: Review of residents medical records and LTCH shift change logs, missing resident policy, resident sign-out log, and interviews with staff members.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following

has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of improper care or incompetent treatment or care of a resident was immediately reported to the Director. On a day in May 2025, a resident reported to a staff member that someone had hurt them and showed them an injury. Staff were made aware of this allegation, however this was not followed up until the next day during the managers meeting to review the weekend progress notes. No critical incident was reported to date.

Sources: Review of resident's health care records; interview with Administrator, complainant and resident.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of staff to resident neglect was immediately reported to the Director. The incident was reported several days later via the Critical Incident System. (CIS).

Sources: review of CIS #2886-000016-25 and the home's investigation package; interviews with staff and the Administrator.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 3.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

The licensee has failed to ensure that strategies to transfer and position a resident to reduce and prevent skin breakdown, including the use of equipment, supplies, devices and positioning aids. The plan of care did not have strategies in place to prevent skin breakdown during transfers and positioning for a resident.

Sources: Interviews with resident and staff, Review of resident's health care records.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the

assessment and that the plan is implemented;

The licensee has failed to ensure that each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented. On a day in April 2025, by not assisting the resident to the toilet for several hours, the staff responsible for providing care to a resident failed to provide bowel and bladder continence assistance in accordance with the resident's individualized plan.

Sources: Review of resident's medical records and LTCH investigation notes, interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that a resident, who is unable to toilet independently all of the time received assistance from staff to manage and maintain continence.

On two occasions in June 2025, a resident requested and did not receive the continence assistance they required to manage their continence needs.

Sources: Resident's health care records reviewed; interview with resident.