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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Public Report

Report Issue Date: July 17, 2025
Inspection Number: 2025-1371-0004
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): July 14, 15, 16, 17, 2025.

The following intake(s) were inspected:

Critical Incident (CI)

- Intake:#0014909-CI 2886-000022-25 - related to an alleged staff to a resident abuse
- Intake: #00150481-CI 2886-000032-25 - related to a fall of resident resulting in injury.

Complaint

- Intake: #00150971 - Complaint -related to concerns with multiple resident care areas

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

Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a staff member used safe and appropriate transfer techniques in accordance with a resident's plan of care.

Specifically, the staff member did not follow the resident transfer needs as indicated in their plan of care.

Sources: Home investigation notes, resident plan of care, interview with a staff, staff member's statements.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the

resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee failed to inform the Director of an incident that caused an injury to a resident , resulting in the resident being taken to hospital. Specifically, the licensee did not notify the Director within three business days of the health related incident, despite receiving confirmation from the hospital of the significant change in the resident's health condition.

Sources: Hospital consultation documentation and progress notes. Interview with staff members.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5)
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out

the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 246/22, s. 115 (5).

The licensee has failed to submit a written report to the Director within 10 days of becoming aware of an incident involving a resident as required under subsection 115(5), paragraphs 1 to 4 of the Fixing Long-Term Care Act, 2021.

Specifically, a resident was transferred and admitted to hospital following an episode of health issue. Despite being aware of the resident condition, the licensee did not provide the required written report to the Director within the legislated timeframe, as outlined in subsection 115(5).

Sources: Review of Critical incident report System portal (CIS). Interview with a staff member.