Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 1, 2011	2011_134_2886_01Apr111552	Complaint- Log # O-000667

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga, ON, L5R 4B2,
Phone: 289-360-1200 and fax: 289-360-1201

Long-Term Care Home/Foyer de soins de longue durée
Centre de Soins de Longue Durée Montfort, 705,Chemin Montréal, Ottawa, ON, K1K 0T1
fax # 613 746-4238

Name of Inspector(s)/Nom de l'inspecteur(s)
Colette Asselin, # 134

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection following a critical incident.

During the course of the inspection, the inspector spoke to the resident, the resident's POA, the Director of Nursing, a staff member and the Administrator.

During the course of the inspection, the inspector reviewed the resident's health records.

The following Inspection Protocols were used during this inspection:

- Prevention of Abuse, Neglect and Retaliation
- Dignity, Choice and Privacy
- Personal Support Services

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
1 VPC

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NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007, SO. 2007, c 8 s 19

(1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Findings:

1. A staff member witnessed a Personal Support Worker (PSW) pushing a resident's wheelchair without ensuring resident was safely positioned before transferring the resident.
2. The witness reported that the PSW left the resident in the room and walked away while the resident was calling out.
3. According to the witness, the PSW did not respond to the resident's call and did not report the incident to the nurse in charge.

Inspector ID #:	134

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by taking immediate action to ensure staff use safe positioning and transferring techniques before attempting to move or transfer a resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O. Reg. 79/10 s. 98

Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Findings:

1. The police was not notified immediately of the alleged incident of abuse and neglect of a resident.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Colette Asseli
Title: Date:	Date of Report: May 5, 2011