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: April 30, 2024	
Inspection Number: 2024-1488-0002	
Inspection Type: Critical Incident	
Licensee: Centre d'Accueil Roger Seguin	
Long Term Care Home and City: Centre d'Accueil Roger Seguin, Clarence Creek	
Lead Inspector Maryse Lapensee (000727)	**Inspector Digital Signature** Maryse C Lapensee Digitally signed by Maryse C Lapensee Date: 2024.05.08 10:05:03 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17, 18, 22, 23, 2024

The following intake(s) were inspected:

- Intake: #00108150/CI #2988-000004-24 - related to a fall with injury.
- Intake: #00110700/CI #2988-000007-24 - related to alleged abuse/neglect of staff to resident.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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.

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

Rationale and Summary
Inspector observed a fall prevention implemented intervention for a specific resident. In April, 2024, in the fall prevention section of a resident's written plan of care, the fall prevention implemented intervention the inspector observed was not included. After a fall in February 2024, the resident was assessed requiring a fall prevention intervention. A Registered Practical Nurse (RPN) and a Registered Nurse (RN) confirmed that the intervention for fall prevention included the fall prevention

implemented intervention observed by the inspector. The RN acknowledged that the written care plan was not reflecting that.
On April 23, 2024, the resident's written care plan was updated to reflect that the resident's fall prevention implemented intervention the inspector observed.

Sources: Observations, a resident's health records, interview with a RPN and a RN. [000727]

Date Remedy Implemented: April 23, 2024

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure that the assessment and monitoring of a resident's restraint was documented.

Rationale and Summary
In April, 2024, a resident was observed sitting in their wheelchair with a restraint applied.

The resident's restraint monitoring sheet for the month of April was missing hourly documentation. Missing documentation for the day shift and evening shift on three specific days. Missing registered staff assessment sign off for the day shift on six occasions, and missing every registered staff assessment sign off on evening shift during a specific timeframe in April 2024. No documentation in the resident's progress notes indicating that they were not using their wheelchair and restraint.

A Personal Support Worker (PSW) acknowledged that PSWs were responsible to check a resident with a restraint every hour and to reposition the resident every two hours. The PSW confirmed that they must document every hour in the restraint book located at the nursing station.

A Registered Nurse (RN) confirmed that the PSW were aware about monitoring the resident with restraint every hour and that they must sign and that the registered staff must sign off on every shift that the resident was using the restraint.

The Director of Care (DOC) stated that the expectations for the PSW regarding a resident with a restraint, were to document every hour when the resident was using the restraint. Registered staff must verify every shift that it is done and sign off.

Both the RN and the DOC confirmed that documentation and signatures were missing for a resident's restraint monitoring sheet for the month of April 2024.

As such, not documenting the monitoring of the restraint may have potentially put the resident at risk of improper assessment.

Sources: A resident's health records, interview with a PSW, a RN and the DOC. [000727]