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

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| Report Issue Date: June 19, 2024 | |
| Inspection Number: 2024-1488-0003 | |
| Inspection Type:<br>Complaint<br>Critical Incident | |
| Licensee: Centre d'Accueil Roger Seguin | |
| Long Term Care Home and City: Centre d'Accueil Roger Seguin, Clarence Creek | |
| Lead Inspector<br>Julienne NgoNloga (502) | Inspector Digital Signature |
| Additional Inspector(s)<br>Colin Moore (000858) | |

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6, 7, 10, 13, 17, 18, 19, 2024

The following intake(s) were inspected:
Critical Incident System Report (CIS):

- Intake: #00112201 (CIS #2988-000011-24) -related to continence care and reporting and complaint
- Intake: #00114312 -(CIS# 2988-000018-24) and Intake: #00115754 (CIS# 2988-000025-24) related to fall of residents resulting in injury.
- Intake: #00115265 - (CIS# 2988-000021-24) - related to an altercation between residents resulting in injury

- Intake: #00115379 - (CIS# 2988-000022-24) - related to allegation of resident to resident abuse.
- Intake: #00115743 - (CIS# 2988-000024-24)- related to allegation of staff to resident abuse.

Complaint

- Intake: #00115605 - related to allegation of resident to resident abuse.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised at any other time when the fall prevention strategies set

out in the plan were not effective after multiple falls during a specified period of time.

Sources: Inspector's observation, interviews with multiple staff members, review of a resident's post-fall assessments record, plan of care, and progress notes. [000858]

## WRITTEN NOTIFICATION: Accommodation services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that a hydraulic door closing mechanism was maintained in a good state of repair.

Sources: Inspectors observations, video footage. Interview with a staff member. [502]

## WRITTEN NOTIFICATION: Fall Prevention

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted

using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246 / 22, s. 54 (2); O. Reg. 66 / 23, s. 11.

A- The licensee has failed to ensure that after a resident had fallen on several occasions, that the post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Sources: Interview with multiple staff, review of resident's post-fall assessment record, progress notes. [000858]

B- The licensee has failed to ensure that after another resident had fallen, that the post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Sources: Interview with multiple staff, review resident's post-fall assessment record, progress notes. [000858]