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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: January 23, 2025
Inspection Number: 2025-1488-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Centre d'Accueil Roger Seguin
Long Term Care Home and City: Centre d'Accueil Roger Seguin, Clarence Creek

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 10, 13-17, 20-23, 2025.

The following intake was inspected:

- Intake: #00136143 - PCI

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain 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) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's assistive device and the type of continence care product had changed.

The resident's initial plan of care was implemented upon their admission. The resident's health had deteriorated, and changes had been made to their assistive device and continence care product. A Registered Nurse (RN) indicated that the plan of care had not been revised.

Sources: Resident's plan of care. Interviews with Personal Support Worker (PSW) , RN ,and a resident's Substitute Decision Maker (SDM)

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 the ceiling in the main floor dining room was maintained in a safe condition and in a good state of repair.

A part of the ceiling drywall in the main dining room noted to be missing due to water damage and the ceiling tiles in the servery were missing exposing the pipes inside the ceiling.

Environmental service Manager (ESM) indicated that while staff were decorating the room for an event, the ceiling drywall crumbled, due to an accumulation of condensation that started during the summer months . No temporary intervention was in pace at the time of this inspection.

Sources: Inspector's observation. Interview with ESM.

WRITTEN NOTIFICATION: Use of PASD

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The licensee has failed to ensure that a resident's assistive device used as a personal assistance services device (PASD), was included in the resident's plan of care.

Two Registered Practical Nurses (RPN)s indicated that the resident required the assistive device to promote the resident's independence.

Sources: Inspector's observation. Interview with RPNs

WRITTEN NOTIFICATION: Resident and Family Experience Survey

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (a)
Resident and Family / Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (4);

The licensee has failed to ensure that the annual Resident and Family Experience survey results were made available to the Resident council.
The Resident / Family council assistant indicated during an interview, that the survey results had not been shared with the council.

Sources: 2024 Resident / Family council minutes; Resident council assistant interview.

WRITTEN NOTIFICATION: Pain Management program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section

53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that their Pain Management program was annually evaluated and updated.
During an interview, the Administrator indicated that no evaluation of the Pain Management program had been conducted in 2024.

Sources : Interview with Administrator, record review "Evaluation et analyse du programme de la gestion de la douleur 2024 .

WRITTEN NOTIFICATION: Skin and Wound program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the Skin and Wound program had been evaluated and updated in 2024 in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Administrator indicated that the skin and wound program had not been evaluated in 2024.

Sources: Interview with the Administrator

WRITTEN NOTIFICATION: Pain Management program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246 / 22, s. 53 (1); O. Reg. 66 / 23, s. 10.

The licensee has failed to ensure that the Pain Management program was developed as an interdisciplinary program.

During an interview, the Director of Care / Pain Management Lead indicated that the program was developed and implemented by nursing and not interdisciplinary.

Sources : Interview DOC / Pain Management Lead ; record review Pain Management program.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)
Infection prevention and control program
s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead

whose primary responsibility is the home's infection prevention and control program.

The licensee has failed to ensure that the home has an Infection Prevention and Control (IPAC) Lead whose primary responsibility is the home's Infection Prevention and Control program.
During an interview, the DOC indicated that the licensee had no primary IPAC Lead.

Sources : DOC interview.

WRITTEN NOTIFICATION: Medication Management system

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 125 (1)
Annual evaluation
s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure an annual evaluation of the Medication Management system.
During an interview, the DOC indicated that no annual evaluation had been conducted for 2024.

Sources: DOC interview.

WRITTEN NOTIFICATION: Continuous Quality Improvement committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that a Personal Support Worker (PSW) was part of the licensee's Continuous Quality Improvement committee .
During an interview , the Administrator confirmed that no PSW was part of this committee.

Sources : Administrator interview.

WRITTEN NOTIFICATION: Emergency plans

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 268 (8) (a)
Emergency plans
s. 268 (8) The licensee shall ensure that the emergency plans for the home are evaluated and updated,
(a) at least annually, including the updating of all emergency contact information of the entities referred to in paragraph 4 of subsection 268 (4); and

The licensee has failed to ensure that their Emergency plans were evaluated and updated at least annually.

Upon review of the licensee's Emergency plan binder, revision dates for their policies were September 2011 and October 2018.
During an interview, the Environmental manager acknowledged the dates and confirmed that the Emergency plans had not been updated annually.

Sources: Emergency plan binder, Environmental manager interview.

WRITTEN NOTIFICATION: Continuous Quality Improvement initiative report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 271 (1) (e)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to publish their recent copy of their Continuous Quality Improvement initiative report on their website . Last publishing was dated 2018-2019.

Sources : Centre d'Acceuil Roger Seguin website

WRITTEN NOTIFICATION: Website

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 271 (1) (f)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,

(f) the current version of the emergency plans for the home as provided for in section 268;

The licensee has failed to publish their Emergency plan on their website .

Sources : Centre d'Acceuil Roger Seguin website