Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 17, 2021	2021_621755_0012	011502-20, 023363-20, 025159-20, 001165-21, 001781-21, 002695-21	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Montfort
705 Montreal Road Ottawa ON K1K 0M9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MANON NIGHBOR (755)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 13, 14, 17- 21, 25, 26, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #001165-21, (CIS #2886-000001-21) and log #023363-20, (CIS #2886-000017-20) were related to staff towards resident alleged abuse, specifically regarding continence care and dining service.
Log #001781-21, (CIS #2886-000003-21) and log #025159-20, (CIS #2886-000019-20) and log #011502-20, (CIS #2886-000010-20) were related to falls.
Log #002695-21, (CIS #2886-000005-21) was related to resident to resident alleged sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurse (RPN), Responsive Behaviour Specialist (BSO), Personal Support Workers (PSWs), Infection Prevention and Control (IPAC) Manager, Residential Assessment Instrument (RAI) Coordinator, Resident Coordinator, Manager of Environmental Services, Office Manager, Interim Food Services Manager, Quality Control Manager, Housekeeping staff, Cook, agency housekeeping staff, COVID-19 front entrance screeners and residents.

During the course of the inspection the inspector observed resident and staff interactions and resident's environment and reviewed clinical health records, Fall Prevention and Injury Reduction - Post Fall Management and Head Injury Routine and Dementia Care-Responsive Behaviour Procedures, Service Area Temperature Forms, food temperature records and staff schedules.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Neurogical Flowsheet, Head Injury Routine Procedure included in the Fall Prevention and Injury Reduction policy and procedure was complied with, for the resident.

O. Reg. 79/10 s. 48. (1) 1. requires a falls prevention and management program to reduce the incidence of falls and the risk of injury is implemented in the home.

O. Reg. 79/10 s. 30. (1) 1. requires that the fall and prevention program must be a written description of the program that includes relevant policies, procedures and protocols and provides for methods to monitor outcomes.

Specifically, staff did not comply with the licensee's Head Injury Routine Procedure included in the Fall Prevention and Injury Reduction policy and procedure.

The resident was found laying on the floor in their bedroom. The licensee's Fall Prevention and Injury Reduction, Head Injury Routine Procedure states that if a fall is unwitnessed, the Head Injury Routine is initiated. The Head Injury, Neurological Flowsheet, Glasgow coma scale and vitals signs frequency is as follow; every 30 minutes for two hours, every hour for six hours, every four hours for eight hours and every eight hours for 56 hours, monitoring for a total of 72 hours.
The resident's Glasgow Coma Scale and vital signs post fall was initiated and the frequency was not followed, as per the licensee's Head Injury Routine Procedure.

Sources
Fall Prevention and Injury Reduction, Head Injury Routine and Neurological Flowsheet Procedure, CARE5-010.05, Effective January 2018, reviewed on March 31, 2021.
Post Fall Assessment and progress notes.
Interviews with staff.

2. The licensee has failed to ensure that the Dementia Observation System tracking tool (BSO-DOS) included in the Responsive Behaviour Policy and Procedure related to Dementia Care, was complied with, for the resident.

O. Reg. 79/10, s 53. (1) requires written strategies, including interventions, to prevent, minimize or respond to the responsive behaviours and resident monitoring.

Specifically, staff did not comply with the licensee's Responsive Behaviour Policy and Procedure.

The resident, was found wandering into an another resident's bedroom and touched them in an inappropriate manner. A Dementia Observation System tracking tool (BSO-DOS) was initiated as per the licensee's Dementia Care, Responsive Behaviour Procedure which states that after a sexual responsive behaviour which consent is not provided or resident is not capable of providing, to initiate a Behaviour Tracking Tool for Resident Offender (BSO-DOS) and ensure there is documentation every shift for three days.
The BSO-DOS tracking tool was not completed, according to the licensee's Responsive Behaviour procedure.

Sources
Progress notes.
Dementia Observation System tracking tool (BSO-DOS).
Dementia Care, CARE3.010.02, Responsive Behaviour Procedure, effective September 30,2019, reviewed March 31, 2021.
Interviews with staff.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff implement the infection prevention and control program, by donning the required droplet and contact precaution, personal protective equipment (PPE).

During the course of the inspection, the Inspector observed a staff, that was not wearing all of the required droplet and contact precaution PPE, when providing direct care to the resident.

Sources:
May 20, 2021: Inspector's observation and interviews with IPAC Manager, DOC and staff #115.
COVID-19 -Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007. Effective Date of Implementation: May 4, 2021. [s. 229. (4)]

Issued on this 18th day of June, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.