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

Original Public Report

Report Issue Date: November 7, 2024
Inspection Number: 2024-1371-0005
Inspection Type: Critical Incident
Licensee: Santé Montfort
Long Term Care Home and City: Montfort, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 5, 6, 7, 2024

The following intake(s) were inspected:

- Intake: #00125044, Critical Incident (CI) 2886-000013-24 related to an allegation of sexual abuse of resident to resident
- Intake: #00126471, CI #2886-000016-24 related to Improper/Incompetent treatment of a resident
- Intake: #00126577, CI #2886-000015-24 related to an allegation of emotional abuse staff to resident.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1) The licensee has failed to ensure that an allegation of verbal / emotional abuse, staff to resident was immediately reported to the Director. The incident was reported two days later via the Critical Incident System. (CIS).

Sources: CIS and interviews with a Registered Practical Nurse (RPN) and with the Executive Director.

2) The licensee has failed to ensure that an allegation of sexual abuse, resident to resident was immediately reported to the Director. The incident was reported the following day via the After-Hours System.

Sources: CIS and interviews with a RPN.