Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 26, 2019	2019_583117_0019	024252-17, 008552-18, 008893-18, 010110-18, 010789-18, 012250-18, 021382-18, 027294-18, 027762-18, 029320-18	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

LYNE DUCHESNE (117), LINDA HARKINS (126)

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): April 9, 10, 11, 12, 15, 16, 17, 18 and 24, 2019

During this inspection, the following critical incident logs were inspected:
• Log #024252-17: related to a critical incident report (CIS # 2886-000034-17) of an alleged incident of resident to resident sexual abuse.
• Log #008552-18: related to a critical incident report (CIS #2886-000005-18) of an alleged incident of resident to resident physical abuse.
• Log #008893-18: related to a critical incident report (CIS # 2886-000006-18) of an alleged incident of staff to resident verbal abuse
• Log #010110-18: related to a critical incident report (CIS #2886-000008-18) of an alleged incident of staff to resident verbal/emotional abuse.
• Log #010789-18: related to a critical incident report (CIS #2886-000009-18) of an alleged incident of resident to resident physical abuse
• Log #012250-18: related to a critical incident report (CIS #2886-000011-18) of an incident where a resident is taken to hospital and which results in a significant change in the resident's health status
• Log #021382-18: related to a critical incident report (CIS #2886-000016-18) of an incident where a resident is taken to hospital and which results in a significant change in the resident's health status
• Log #027294-18: related to a critical incident report (CIS #2886-000019-18) of an incident where a resident is taken to hospital and which results in a significant change in the resident's health status
• Log #027762-18: related to a critical incident report (CIS #2886-000020-18) of an incident of a missing resident less than 3 Hours
• Log #029320-18: related to a critical incident report (CIS #2886-000021-18) of an alleged incident of resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Associate Director of Care, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), a Physiotherapist, an activity aide, as well as several residents.

During the course of the inspection, the inspector reviewed several resident health care records, observed resident to resident interactions, observed staff to resident interactions and provision of care, as well as reviewed the home's internal investigation reports related to the submitted critical incident reports.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee informed the Director no later than one business day after the occurrence of the incident of:
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. (Log # 027762-18)

Resident #011 is identified as being a wanderer. On specified day in 2018, resident #011 eloped from the home. The resident was returned to the home within 15 minutes. The resident had no injuries.

The home submitted a Critical Incident Report (CIS) # 2886-000020-18 on specified day in 2018, 11 days after the resident had eloped from the home. The Director of Care said that they had not reported the incident within one business day as they were not aware of the reporting requirements for residents who are missing for less than three hours and who return to the home with no injury. [s. 107. (3)]

Issued on this 26th day of April, 2019

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

Original report signed by the inspector.