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

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Original Public Report

Report Issue Date: April 10, 2024	
Inspection Number: 2024-1371-0002	
Inspection Type: Other Complaint Critical Incident	
Licensee: Santé Montfort	
Long Term Care Home and City: Montfort, Ottawa	
Lead Inspector Julienne NgoNloga (502)	**Inspector Digital Signature** Julienne Ngo Nloga Digitally signed by Julienne Ngo Nloga Date: 2024.04.15 10:32:13 -04'00'
Additional Inspector(s) Mildred Ababio (808) was present throughout the inspection as an observer.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 14, 15, 18, 19, 20, 21, 22, 25, 2024

The following intake(s) were inspected:
Complaints:

- Intake: #00098864 and #00098871 related to a resident care and rehabilitation services.
- Intake: #00111570 related to a resident's plan of care .

Critical Incident System Report

- Intake: #00099536 (CIS #2886-000034-23) related to a fall of a resident resulting in injury

- Intake: #00111536 (CIS #2886-000005-24) related to improper transfers of a resident.

Follow-up

- Intake: #00106023 related to transferring and positioning techniques

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the secured unit of the home was a safe and secure environment for its residents.

Rationale and summary
A day in March 2024, for an identified period in a specified home area, the inspector observed construction material left unsecured and unattended in the hallway with no staff insight. Three residents were observed in the hallways. This was brought to the attention of two staff members, who indicated that the contractor may have gone on break and the construction material should not be left unattended and unsupervised. Both staff members did not secure the construction material.

A management staff stated they advised the contractor prior not to leave working construction materials unattended, specifically in the specified unit as the residents in that unit touch anything they have access to.

By leaving construction material unsecured and unattended placed the residents in the specified unit at risk of injury.

Sources:
Inspector's observation, Interviews with three staff members.
[502]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based

on an assessment of a resident and on the needs and preferences of that resident.

Rationale and Summary
Review of a resident's Recreation Assessment completed during admission in 2023, indicated that the resident was admitted in the Long-Term Care home to rest and would not be participating in activities. They documented the resident's sources of daily strength. The assessment showed that a specified activities make the resident happy.

Review of the resident's current plan of care showed that the resident required assistance to be involved in social and recreational activities. Under interventions it was noted that the resident enjoyed group programs.
Review of Recreation and social activity report for an identified period in 2024, showed that the resident declined to participate in group activities.

Interview with three staff members indicated that the resident refused to attend most of the activities offered and displayed behaviours when staff wheeled them to group activities, until they transferred the resident back to their room.

By not developing a care plan to reflect the resident's needs and preference identified during the admission process, the resident's participation in activities may have been limited.

Sources: Review of a resident's recreation assessment, plan of care. Interview with staff members.
[502]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the daily mass and rosary set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
On two occasions in 2024, a resident was observed seated on a tilted wheelchair facing a television (TV) that was turned off. A white board was noted on the wall which outline the specified activity schedule.

Review of the resident's care plan indicated that the goal was to involve the resident in a specified activities.
Review of the resident activities report for an identified period in 2024, showed that the resident attended two out of four specified activity offered in group.

Interviews with two staff members stated that they were not aware of the resident's schedule for the specified daily activities as it was the nursing staff responsibility to provide the activity. Interview with a third staff member indicated that the recreation and activity department was responsible to provide activities to the resident as per the plan.

By not respecting the activity schedule on the white board, the specified daily activities were not provided to the resident as per the plan of care.

Sources: Resident's white board notes, Resident's social and recreational activity report. Interviews with three staff members.
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WRITTEN NOTIFICATION: Plan of Care

NC #004 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

The licensee has failed to ensure that a resident was reassessed after specified symptoms occurred.

Rationale and Summary
A resident's progress notes showed that the resident had specified symptoms on three occasions in 2024. The progress notes and medical administration record (eMAR) showed that on specified medications were administered to the resident for identified behaviours with little effect.

Four staff members indicated in interviews that they provided an identified care for the resident each time the resident had specified symptoms before informing the a registered staff member. Staff indicated that the resident displayed the identified behaviours throughout an identified shift and did not sleep. Staff members stated that they provided care and left the resident resting in bed at a 30-degree angle,

before informing the registered staff member about the last occurrence of the symptom.

The registered staff member stated that they were aware of the resident's symptoms, but staff members provided care before they could assess the resident. When the registered staff member went to check on the resident a few minutes after they were informed of the last symptoms, they found the resident unresponsive. The physician noted a specific condition as the cause of death.

Two staff members indicated that registered staff members are expected to assess the resident when there is a significant change in health condition, then notify the physician and Substitute Decision Maker (SDM).

By not reassessing the resident after noting symptoms in three occasions, the signs of a specified condition may have been overlooked.

Sources: Record review of resident's progress notes, eMAR, Death Certificate, and resident's Care Plan. Interviews with six staff members,
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WRITTEN NOTIFICATION: Doors In the Home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept

closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the servery's door leading to non-residential areas was kept closed and locked when it was not being supervised by staff.

Rationale and Summary
On two occasions during this inspection, the door leading to a servery was opened and unsupervised, a hot water tower placed on the counter was easily accessible to residents. On both occasions, the residents were present in the dining room with no staff present.

This was brought to a management staff 's attention, they stated that the servery is a non-resident area and should be locked when not in use by staff.

By leaving the servery's door open and unsupervised, residents were at risk of accessing hot water in the servery.

Sources: Inspector's observation, Interview with a management staff.
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WRITTEN NOTIFICATION: Transfer and Repositioning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The license has failed to ensure that a staff member used safe transferring devices

or techniques when assisting a resident.

Rationale and Summary:
A day in March 2024, a resident was observed on a sit-to-stand lift while a staff member provided peri-care, then the staff member transferred the resident from toilet to wheelchair without assistance of a second staff.

Review of the home's Safe Resident Handling procedure #CARE6-010.07-LTC revised on March 31, 2023, required that two staff be present at all times while the mechanical device is in operation.

Interview with management staff stated that all transfers with a lift required two people.

By transferring the resident with the sit-to-stand lift without assistance of a second staff, the resident was at risk of injury.

Sources: Inspector's observation. Review of the home's Safe Resident Handling procedure #CARE6-010.07-LTC. Interview with a staff member.
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WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

Specifically, under the Infection Prevention and Control (IPAC) Standard: 9.1 where the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At a minimum, routine practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene.

Rationale and summary
On two occasions in March 2024, two staff members had not performed hand hygiene as per minimum routine practices, infection prevention and control standards during the a snack service and after providing care respectively.

The IPAC Lead acknowledged that both staff members did not follow the routine practices and additional precautions.

The failure to perform hand hygiene between residents' care placed residents at a moderate risk for cross-contamination.

Sources: Inspector's observations, and interviews with IPAC Lead.
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