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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 15, 2017	2017_621547_0015	003713-17	Complaint

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 19, 20, 21, 22, 25, 26, 29, and October 3, 2017

This inspection was related to a complaint made regarding care and services related to meal provision and lost items in the home.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Resident Assessment Instrument (RAI) Coordinator, the Office Manager, a staffing clerk, Physiotherapy Assistant (PTA), the Nutritional Manager, the Dietitian, the Extendicare Assist LTC nursing consultant and the Administrator.

In addition, over the course of the inspection, the inspector reviewed residents' health care records, staff work routines, observed resident rooms, resident common areas, reviewed policies related to infection control practices and lost items in the home. The inspector observed the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure to immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director of the Ministry of Health.

On a specified date, inspector #547 spoke to resident #001's Substitute Decision Maker (SDM) regarding a complaint made to the Director of the Ministry of Health (MOH) regarding care and services related to meal provision and lost items in the home. The resident's SDM indicated that he/she was frustrated with the home, as he/she had made the same complaint approximately four months earlier and had not heard anything about his/her concerns. The situation was ongoing, and the home had not done anything to rectify his/her concerns. The SDM forwarded the Inspector his/her written complaint made to the home on a specified date four months earlier, that was directed to the acting Administrator at the time of the complaint. This written complaint identified concerns related to care and services for meal provision to resident #001 and to lost items in the home.

On October 3, 2017 the current Administrator indicated to Inspector #547 that he had contacted the previous acting Administrator and they could not locate any information regarding this written complaint and can only assume that it was overlooked at that time.

As such, the written complaint concerning resident #001's care and operation of the home was not forwarded to the Director as required by this section. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure to immediately forward written complaints that have been received concerning care of a resident or operation of the home to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as required by this section.

This is specifically related to this written complaint not being investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, has the investigation commenced immediately.

This inspection is related to a written complaint made to the home on a specified date via email to the acting Administrator regarding care and services related to meal provision to the resident and missing items in the home.

The current Administrator was not able to locate any file related to this written complaint or response. He contacted the acting Administrator at the time of this complaint, and no investigation or response documentation from the Licensee was located in order to be provided to the inspector over the course of this inspection. The Administrator indicated that it is quite possible, that with the change management issues going on in the home at the time of the complaint, that this was overlooked.

As such, the Licensee was not able to provide any investigation documentation records related to this written complaint to indicate the date the complaint was received, the type of actions taken to resolved the complaint, including the date of the action, time frames of those actions and follow-up actions required to the complainant for this written complaint. The Licensee was not able to provide any documentation of records of any date on which a response was provided to the complainant and a description of the response and any responses made in turn by the complainant. The Licensee has further failed to provide any documented record to indicate that this complaint would be reviewed or analyzed for trends quarterly, to determine what improvements are required in the home; and written records of each review related to complaints. [s. 101.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written or verbal complaints made to the Licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible and a response provided to the complainant within 10 business days of receipt of the complaint, to be implemented voluntarily.

Issued on this 28th day of November, 2017

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

Original report signed by the inspector.