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
Jan 9, 2018	2017_619550_0026	027613-17	Critical Incident System

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

JOANNE HENRIE (550)

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): December 4 and 5, 2017.

This inspection is related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), several Registered Nurses (RN) and several Personal Support Workers (PSW).

In addition, the inspector reviewed a critical incident report and a resident's health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specified date in 2017, an incident was reported to the Director through the Action Line followed by the submission a Critical Incident (CIS) report. It was reported that on another specific date and time resident #001 had sustained a fall with injuries and was transferred to the hospital where the resident was diagnosed with a specific type of injury. The resident later passed away in the hospital.

Inspector #550 reviewed the resident's health care records. Resident #001 was admitted to the home in 2015 with multiple diagnoses. The current plan of care dated a specified date in 2017 indicated that the resident was at high risk for falls. Resident #001 required extensive assistance of one staff for all transfers and needed to be reminded to call for assistance when he/she wanted to transfer. The progress notes were reviewed for a specified period of six months and identified that the resident had one fall in that period of time. On a specified date, resident #001 had attempted to transfer on his/her own to go to the washroom and had been found on the floor with no injuries. Following this incident new interventions had been added to the care plan including to apply a specified device to the resident while the resident was in bed and enhanced monitoring with safety checks at a specified interval.

During an interview on December 4, 2017, PSW #100 who was the PSW caring for the resident on the date of the latest fall, he indicated to the inspector that he had toileted resident #001 at a specified time and had checked on the resident regularly after, in between the care of other residents. PSW #100 indicated that he had given the resident the specified device in the resident's hand when he put the resident to bed so the resident use this device to call for assistance if needed. Approximately one hour later while he was doing his last round before the end of his shift, PSW #100 found the resident on the floor in his/her room. The resident was found in a specific position and had sustained injuries to specific body parts. The resident was not able to explain how the incident had occurred and was immediately transferred to the hospital. PSW#100 indicated to the inspector being aware that resident #001 required a specified device to be applied to the resident when the resident was in bed but the resident had refused and had preferred to hold the device in his/her hand.

On December 5, 2017, inspector #550 interviewed PSW #101 and PSW #102 who regularly cared for resident #001. They indicated to the inspector that resident #001 required the assistance of one staff for all transfers but that often the resident was not compliant; resident #001 would often self transfer. Both PSWs indicated they were not aware that the resident required close monitoring with safety checks at a specified interval therefore they did not monitor the resident as per the requirement in the care

plan.

The inspector reviewed resident #001's plan of care with the Director of Care. The DOC indicated to the inspector that because the resident was at high risk for falls and was not always compliant with requesting staff's assistance for transfers, the resident required to be closely monitored by staff. Safety checks needed to be done at specified intervals and required to have a specified device applied to the resident while in bed to alert staff when he/she attempted to self transfer. The Director of Care indicated to the inspector that the care set out in the plan of care was not provided to resident #001 as it was specified in the plan. [s. 6. (7)]

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 the care set out in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.

Issued on this 7th day of February, 2018

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

Original report signed by the inspector.