Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Aug 22, 2019	2019_730593_0024	011195-19	Complaint

Licensee/Titulaire de permis

CVH (No. 4) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes 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

GILLIAN CHAMBERLIN (593)

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): August 6 - 7, 15 - 16, 2019.

Complaint log #011195-19 was inspected related to alleged improper treatment of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nursing staff, Personal Support Worker's (PSW) and family members.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment and reviewed resident 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)**
- **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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 2. An unexpected or sudden death, including a death resulting from an accident or suicide.

A complaint was received through the Action Line, by a family member of resident #001. It was alleged that resident #001 sustained a fall and then two days later passed away. It was alleged that the fall may have contributed to the sudden passing of resident #001.

A review of the progress notes for resident #001 found the following (summary):

Day one- Resident #001 was confused, a bodily fluid sample was taken for testing.

Day two- Resident #001 was anxious.

Day three- Resident #001 was agitated, anxious and confused, resident #001 was wandering. Resident #001 sustained a fall, no apparent injuries sustained. Resident #001 complained of specific pain. Order for antibiotic was prescribed by the home's physician.

Day four- Resident #001 was wandering and remained confused. At approximately 2200 hours, resident #001 was found on the floor with vital signs absent, paramedics called, physician called, POA called. Resident #001 pronounced dead.

During an interview with Inspector #593, August 15, 2019, RPN #101 reported that resident #001 was confused and wandering during their shift before they passed away. RPN #101 reported that they were concerned for the resident and with the assistance of a PSW, they took the resident back to their room to rest. The RPN left for 20 minutes and when they came back to check on the resident, the resident was on the floor unresponsive with absent vital signs. RPN #101 reported that resident #001 had passed away. RPN #101 indicated that this death was unexpected as other that being treated for an infection, there was no indication that the resident was unwell until the moments before their death.

Inspector #593 reviewed the Critical Incident System (CIS). There was no CIS submitted for the sudden and unexpected death of resident #001. As such, the licensee has failed

to ensure that the Director was informed of the sudden and unexpected death of resident #001. [s. 107. (1) 2.]

Issued on this 23rd day of August, 2019

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

Original report signed by the inspector.