Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Feb 4, 2020	2020_683126_0001	020227-19, 021341-19	Critical Incident System

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

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): On January 16, 17, 20, 21, 2020

During this inspection the following logs were inspected:
Logs # 020227-19 and 021341-19 related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in
the resident's health status.

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

During the course of this inspection, residents were observed during the course of the day.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Pain

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #002 was admitted to the home in 2019. Resident #002 fell during the night shift on a specific date in 2019. The resident was assessed by the night nurse and did not exhibit any pain except for sensitivity to a specific body area.

Resident #002's health care record was reviewed, and the following was documented in the progress notes:

On a specific date in 2019, Registered Nurse (RN) #107 documented that the resident complained of pain. Analgesic was administered with good effect.

On a specific date in 2019, Registered Practical Nurse (RPN) #109 administered an analgesic for pain. RPN #109 also documented on that same day, that the resident had a specific area that was swollen and that it was from an unknown origin.

On a specific date in 2019, RN #101 documented that during a skin assessment they observed altered skin integrity to a specific area.

On a specific date in 2019, RPN #108 documented that during a skin assessment that a specific body area appeared to be oedematous.

On a specific date in 2019, RN #106 sent the resident to the hospital to investigate for a potential fracture.

Interview with RPN #104, indicated that they completed an assessment of the resident on the admission day in 2019. During the observation, they noted that the resident required minimal assistance for transfer.

Interview held with RN #107, indicated that resident #001 was complaining of pain to a specific area and administered analgesic as prescribed with good effect. They indicated that it was the RN at the beginning of the shift who read the daily report and that they did not associated the pain to the resident's fall.

Interview held with RPN #109, indicated that they administered an analgesic for pain. The RPN was not aware that the resident had a fall the previous day and did not associate the pain to the resident's fall.This information was not found in the resident's health care record as the 24 hour plan of care reflected the resident's condition post fall.

Interview with RN #101, indicated that they applied the dressing to a specific body area as the resident was sitting. RN #101 indicated they were not aware that the resident had a fall on a previous day.

Interview held with Personal Support Worker (PSW) #110, indicated that they observed that resident #001 had more difficulty putting weight on his/her feet. PSW indicated that they informed RN #106 about the concern.

Interview held with RN #106, indicated that PSW #110 informed them that resident #001 had difficulty putting weight on his/her feet. RN #106 assessed the resident and sent him/her to the emergency for further assessment. Resident returned with a fracture to a specific body area.

The licensee failed to ensure that resident #001’s post fall/pain assessments completed by registered nursing staff were integrated, consistent and complement each other. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

Issued on this 7th day of February, 2020

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

Original report signed by the inspector.