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

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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
Oct 19, 2020	2020_621755_0018	021020-20	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

MANON NIGHBOR (755)

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 20, 21, 24, 25, 26, 27, 2020.

The following logs #002341-20, 012974-20, 014390-20 were received by the Ministry of Long Term Care.
Log #002341-20, was related to plan of care with medication administration.
Logs #012974-20 and 014390-20 were related to falls.
In reference to log #002341-20 and inspection 2020_621755_0012, a non compliance legislative section was amended and reflected in this inspection and log #021020-20.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with Acting Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS Coordinator) and residents.

The inspector reviewed resident's related clinical health records, the home's Fall Prevention Program, Disclosure of Resident Safety Incidents to Residents/SDM (substitute decision maker) policy, observed the provision of care and resident's environment.

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

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

Findings/Faits saillants :

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

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).

On February 14, 2020 a staff interviewed admitted, having administered a medication whole to the resident who required their medication to be crushed. "When I administered the resident's medication as a whole and gave water, I realized that the resident was not able to swallow."

On January 5, 2020 a staff documented and transcribed in Point Click Care (PCC), a verbal order from a physician, that stated to crush meds.

On August 27, 2020, It was observed in PCC, Electronic Medication Administration Record (EMAR), under Special Instructions to crush meds. This was implemented since January 5, 2020.
A staff indicated "crush meds" would be in the resident's profile in PCC. A staff stated it is nursing knowledge, "c'est une erreure de médicament", which translates to being a medication error.
A staff demonstrated to Inspector on the medication cart's electronic tablet, PCC, EMAR's special instructions for the resident to crush meds.

The licensee did not ensure that that the plan of care set out for the resident involved was provided to the resident as specified in the plan. s. 6 (7). [s. 6.]

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Issued on this 20th day of October, 2020

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

Original report signed by the inspector.