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
Jul 7, 2021	2021_831211_0012	002450-21, 003102-21	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

JOELLE TAILLEFER (211), 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): June 1, 2, 11, 14, 2021 (onsite) and June 15, 16, 2021 (offsite).

During this inspection the following logs were inspected:
Complaint Log #003102-21 and Log #002450-21 related to allegation of physical abuse to a resident from staff members.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), a Registered Practical Nurse (RPN), Physiotherapist, Physiotherapist Assistant, Personal Support Workers (PSWs), Nursing Clerk and Behavioral Supports Ontario Staff Members (BSO) and a resident's family member.

The inspectors reviewed several residents' health care records, PSW documentation in the Daily Care Flow sheet supports MDS sheets, Four Point Rounding sheet, Investigation notes and Zero Tolerance of Resident Abuse and Neglect Programs.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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	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).

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 staff and others involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the plan of care related to the resident's transfer status so that the different aspects of care was integrated and consistent with and complement each other.

Review of a resident's "Physiotherapy Assessment" under transfer status indicated that two persons are required to assist the resident for safety reasons.

The resident's care plan indicated under the section "Transfer" and "Toilet Use" that the resident required extensive assistance by one caregiver for transfer. The section "Bed Mobility" indicated that the resident required extensive assistance by 2 staff members for transfer task. The section "Risk for Fall" indicated to toilet the resident in the early morning.

In an interview with the Physiotherapist, they stated that since the resident's quarterly "Physiotherapy Assessment" under transfer status, indicated that two persons should assist the resident for safety, the resident's care plan should have reflected that the resident was a two staff transfer assist. When there is a change in the quarterly "Physiotherapy Assessment", the physiotherapist or the Physiotherapist Assistant would inform the Registered Nursing Staff verbally.

The licensee has failed to ensure that the quarterly "Physiotherapist Assessment" was transmitted to a Registered Nursing Staff by the Physiotherapist or the Physiotherapist

Assistant.

As a result, the multidisciplinary team didn’t collaborate with each other in the development and implementation of the resident’s plan of care related to the resident’s transfer status so that the different aspects of care were integrated and consistent with and complement each other.

Sources: Resident's health care records, the licensee investigation notes and interview with the Physiotherapist and the Physiotherapist Assistant. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care indicating that the resident required extensive assistance by 2 staff members for bed mobility, was provided to the resident as specified in the plan.

The resident’s care plan indicated under section “Bed Mobility” that the resident required extensive assistance by 2 staff members for transfer task.

In an interview with a staff member that was working during the night shift stated that the resident’s incontinence product was changed with one-person assistance in the early morning since the resident was able to turn in bed by holding the side-rails.

The licensee has failed to ensure that the resident’s care plan was provided to the resident as specified in the plan under “Bed Mobility” that indicated that resident required extensive assistance by 2 staff members for transfer task. [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 staff and others involved in the different aspects of care of the resident collaborate with each other 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, and
-the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including a skin breakdown or skin tears received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Review of the investigation notes indicated that two staff members from the day shift entered the resident’s room in the early morning and they discovered the altered skin integrity on the resident’s body areas. A Registered Nursing Staff was informed by a staff member as soon as the resident's altered skin integrity was discovered. The Registered Nursing Staff assessed the resident’s wounds and stated that they would be returning later to apply the dressings. The Registered Nursing Staff returned to the resident’s room to apply a dressing two and half hours later. The Registered Nursing Staff described the wounds to both body areas as open and red.

The Registered Nursing Staff has failed to ensure that the resident’s wounds to both body areas received immediate treatment and interventions to promote healing and prevent infection when the altered skin integrity were observed on the resident’s both body areas.

Sources: Resident’s health care records, the licensee investigation notes and interview with staff members, a Registered Nursing Staff and the Administrator. [s. 50. (2) (b) (ii)]

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 a resident exhibiting altered skin integrity, including a skin breakdown or skin tears received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, to be implemented voluntarily.

Issued on this 20th day of July, 2021

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

Original report signed by the inspector.