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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 22, 2021	2021_831211_0011	019165-20, 019682-20, 007498-21	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

JOELLE TAILLEFER (211), MANON NIGHBOR (755)

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): May 31, 2021, June 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 2021 (onsite) and July 8, 2021 (offsite).

During this inspection the following logs were inspected:
Logs #019682-20, #019165-20 related to unexpected deaths, and
Log # 007498-21 related to a fall.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Former Acting Director of Care (DOC), Office Manager, Program Manager, Dietary and Support Services Manager, Maintenance, Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS Coordinator), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Service Assistant (RSA), Nursing Clerk, Activity Aides, Behavioral Supports Ontario Staff Member (BSO) and residents.

The inspectors reviewed several residents' health care records, BSO Manoir Marochel Manor sheets, Activities Attendance Record sheets, Weekly Timesheet sheets, an Observation System sheet, Four Point Rounding sheets, Fall Prevention, Zero Tolerance of Resident Abuse and Neglect Programs and observed provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **1 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care that set out the planned care for a resident’s responsive behaviors.

Review of a resident’s Minimum Data Set (MDS) Assessment from a specific month indicated that a resident was identified as exhibiting two responsive behaviors. On the following two months, the resident’s progress notes indicated that the resident exhibited responsive behaviors towards several different residents.

Interview with the DOC stated that those responsive behaviors from the resident were not written in the current resident’s care plan.

Thus, a resident’s current written plan of care did not set out the planned of care related to the resident's responsive behaviors towards co-residents.

Sources: Review of a resident’s health care records and interview with DOC. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in a resident’s plan of care related to staff supervision was provided as specified in the plan.

Review of a resident's Minimum Data Set (MDS) Assessment on a specific month, indicated that the resident had multiple responsive behaviors. The resident's current care plan indicated an intervention to keep the resident busy.

The resident's progress notes within two months, indicated that the resident was involved with several instances of three alleged responsive behaviors involving several different co-residents. In another instance, the resident's progress notes indicated that a staff member needed to intervene to stop the resident's responsive behavior causing co-residents to be afraid of the resident's reaction.

The Program Manager stated and provided the Attendance Activities Record sheets which indicated that a staff supervision was put in place since the beginning of a month for the resident. The Program Manager specified that they didn't have staff supervision for the resident after a certain time for the first 50 days. The Weekly Timesheet indicated that a staff member was assigned to the resident during specific shifts and was frequently assigned to the resident during other shifts. The DOC stated that the resident had Behavioral Supports Ontario (BSO) supervision. The BSO was taking care of other residents when another staff was assigned to the resident.

Review of the resident's health care records indicated that the resident exhibited responsive behaviors towards co-residents as followed:
-On a day, the "Manoir Marochel Manor-BSO" sheet indicated that the resident exhibited two specifics responsive behaviors towards two residents. The DOC stated that the incident occurred during a specific shift and the resident was supervised by a staff member. Interview with the staff member acknowledged supervising the resident during that incident but was unable to intervene before the resident exhibited the responsive behavior towards one of the residents.
-The next day, a Registered Nursing Staff documented that the resident exhibited a responsive behavior towards a resident. A staff member validated to be the staff member assigned to supervised the resident on that date. At the time, the resident was supervised by a co-worker when the resident exhibited responsive behavior toward a resident.
-Eighteen days later, a Registered Nursing Staff documented that a staff member reported at the start of the shift that the resident exhibited responsive behavior toward a resident. The staff member validated to be the staff member assigned to supervised the resident on that date. The resident was observed exhibiting a responsive behavior toward a resident, but at the time they were too far away to intervene.

-Five days later, a Registered Nursing Staff documented that a resident reported that the resident tried several times to exhibited responsive behavior toward them, but the incidents were not witnessed by another person. The “Attendance Record Activities” sheet indicated that a staff supervision was assigned for the resident during that period.
-Twenty-seven days later, a Registered Nursing staff documented that the resident exhibited a responsive behavior toward a resident. The “Attendance Record Activities” sheet indicated that a staff supervision was assigned for the resident during this period.
-Four days later, a Registered Nursing Staff documented being told by a resident that the resident had a responsive behavior toward them. The “Attendance Record Activities” sheet indicated that a staff supervision was assigned for the resident during that period.

According to the “Attendance Record Activities” sheets, the Program Manager validated that the resident had a staff supervision when the resident exhibited responsive behaviors toward a resident on two different dates.

A Registered Nursing Staff stated that the resident might have responsive behavior towards co-residents.

As such, the assignment for a staff supervision for the resident set out in the resident’s plan of care was not provided as specified in the plan since the resident was able to exhibit responsive behaviors towards several residents.

Sources: Review of a residents’s MDS Assessment, progress notes, Medication Administration Records, Care Plans, Progress Reports, “Manoir Marochel Manor-BSO” sheet, Attendance Record Activities sheets, Weekly Timesheet sheets and interviews with four Registered Nursing Staff, two PSW/BSOs, a Activity Aide, the DOC and two residents. [s. 6. (7)]

3. The licensee has failed to ensure that a resident’s container had fluid inside it, that they were monitored closely, and the resident didn’t have access to an identified room at all times, as specified in the plan of care.

A resident was found on the floor, in the identified room, presenting with a specific medical condition.

The resident’s plan of care stated, to make sure they did not have access to an identified room, to monitor them closely with 30 minutes checks and to provide them with a specific drinking container.

Three staff confirmed that one of the specific interventions was not put in place since they felt it would not be effective. One staff member said the DOC was informed that one of these specific interventions was not effective and received permission to not follow the specific intervention stated in the plan of care. The staff said that the RAI-MDS Coordinator was aware of the ineffectiveness of the specific intervention. Two staff members confirmed that one of the resident's interventions was not put in place. One staff member had no recollection if the resident had accessibility to another intervention put in place. Another staff member stated that they saw the resident going into the identified room before going to another unit, 15 minutes prior a staff member calling upon them urgently, when resident was discovered. When one of the staff members arrived on the scene, resident was on the floor, in the identified room and passed away thereafter.

Subsequently, not complying to the resident's responsive behavior and interventions as specified in their plan of care, permitted resident access to the identified area, placing them at risk to experience a medical condition secondary to their responsive behavior.

Sources: Resident's plan of care, progress notes, Hospital Discharge Summary Report, laboratories report and interviews with three staff members. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care to use an identified Observation System sheet to monitor a resident's responsive behaviors was documented.

Review of a resident's progress report sheet, indicated to use an identified Observation System sheet to monitor the resident's behaviors.

In an interview with the DOC on a day, they stated they were not aware that the identified Observation System sheet was recommended fourteen days earlier. The RAI Coordinator stated that the identified Observation sheet monitoring recommended for the resident was not found.

As thus, the licensee has failed to ensure that the care set out in the plan of care to use the identified Observation System sheet to monitor the resident's responsive behaviors was documented for fourteen days.

Sources: Review of a resident's progress report sheets, identified Observation System sheet and interviews with RAI Coordinator and the DOC. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that licensee's Code Blue Medical Emergency Policy and Procedure was complied with.

LTCHA s. 87 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including, (a) measures for dealing with emergencies;

O.Reg 79/10 s. 230. (4) The licensee shall ensure that the emergency plans provide for the following: 1. Dealing with, v. medical emergencies.

Specifically, the Licensee's Code Blue Medical Emergency policy and procedure states that the Code Blue Emergency Checklist (Appendix 1) is used to follow and document all required steps to address the emergency. Procedure #6 on page 2, states that as soon as possible after the code is resolved a review of the incident is conducted to determine: What aspects of the response were effective and how the response could be improved.

On a day in September, a resident experienced a sudden deterioration in their health. The progress notes described how the resident's vital signs became absent. The

resident's advanced medical directives indicated that the resident required transfer to an acute care hospital and administration of cardiopulmonary resuscitation (CPR). There was no documentation available related to the resident's code blue medical emergency event describing a summary of interventions.

Two staff confirmed the code blue events should have been documented and a review of the incident had not taken place.

Sources: Code Blue Medical Emergency, policy and procedure, EP-05-01-01, last updated 2016. Resident's progress notes and interviews with two staff. [s. 8. (1)]

2. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

Specifically, the licensee did not comply with the licensee's policy #RC-15-01-01 "Falls Prevention and Management Program" that indicated the following: "If a resident is suspected of hitting their head (e.g., unwitnessed fall), complete Clinical Monitoring Record, Appendix 6. The Clinical Monitoring Record, Appendix 6, indicated to "Monitored the following every hour x 4 hours then every 8 hours x 72 hours;
• Neurovital Signs (If head/brain injury suspected or the fall is unwitnessed)
• Monitor vital Signs
• Assess for pain
• Monitor for Changes in Behavior

Review of the "Post Fall Assessment - V 6" on a day in a month indicated that a resident had an unwitnessed fall. The Clinical Monitoring Record-V4, indicated that the monitoring of the Neurovital Signs for the first two hours were not completed at the time of the fall.

In an interview with a Registered Nursing Staff stated that the resident's fall was unwitnessed, and the monitoring of the Neurovital Signs to be taken every hour for the first 4 hours were not completed as indicated in the Clinical Monitoring Record, Appendix 6.

As such, the Registered Nursing staff didn't complete the "Clinical Monitoring Record" as indicated in the above "Falls Prevention and Management Program" policy, every hour for the first two hours starting when the resident was found on the floor.

Sources: Review of resident's health care records. Interviews with a Registered Nursing staff and two PSWs. [s. 8. (1) (b)]

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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum at least:
-in two resident bedrooms in different parts of the home,
-in one resident common area on every floor of the home, which may include a lounge, dining area or corridor,
-in every designated cooling area, and
-once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Review of the licensee “Extendicare, Temperature and Humidity Log” sheets, including another Temperature log for days, evenings and nights for May and June 2021, recorded by staff members, indicated that the temperature from May 15 to June 6, 2021, was not measured and documented as required.

1-The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

The Administrator validated that the licensee “Extendicare, Temperature and Humidity Log” sheets indicated that the temperatures were measured and documented for only one resident bedrooms in different parts of the home on the following dates:
May 17, 18, 25, 28, 31, 2021, June 1, 2021 only in the morning,
May 21, 2021, June 4, 2021, in the morning and the afternoon.
The Administrator validated that the licensee “Extendicare, Temperature and Humidity Log” sheets indicated that the temperatures were not measured and documented for resident bedrooms on May 15, 16, 19, 20, 22, 23, 24, 26, 27, 29, 30, 2021, June 2, 3, 5, 6, 2021 at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

2-The licensee has failed to ensure that the temperature was measured and documented in writing in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

A review of the home’s Temperature Logs indicated that the temperatures were not measured and documented in one resident common area for the following dates:
May 17, 18, 22, 23, 25, 26, 28, 31, 2021, June 1, 2021, in the afternoon.
May 19, 20, 27, 2021, June 2, 2021 in the afternoon and once in the evening or night.

May 21, 2021, once in the evening or night.
May 24, 2021, once in the morning and once in the afternoon,
June 5, 2021, once in the morning,
May 15, 16, 29, 30, 2021, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

3-The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area in the home.

Interview with the Administrator stated that the lobby, the south and west activity rooms, the south and dining rooms were designated has the cooling areas in the home. A review of the home's Temperature Logs indicated that the temperatures were not measured and documented in every designated cooling area in the home on the following dates:

May 15, 16, 19, 20, 22, 23, 24, 26, 27, 29, 30, 2021, June 2, 3, 5, 6, 2021, in the lobby, both activity rooms and both dining rooms, once in the morning, once in the afternoon and once during the evening or night.
May 17, 18, 25, 28, 31, 2021, June 1, 2021, in the south activity room and both dining rooms, once in the morning and in the lobby, both activity rooms and both dining rooms once in the afternoon and once during the evening or night.
May 21, 2021, June 4, 2021, in the south activity room and both dining rooms, in the morning and once in the afternoon and in the lobby, both activity rooms and both dining rooms once during the evening or night.

There was a risk to resident comfort and safety when the temperatures are not measured and documented in the specified areas of the home during the required time frames.

The licensee has failed to ensure that the temperature is measured and documented in writing as indicated in the above dates.

Sources: Review of the licensee "Extendicare, Temperature and Humidity Log" sheets, temperature log sheets recorded by staff members and interviews with the Administrator and a PSW. [s. 21.]

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 temperature is measured and documented in writing, at a minimum at least:
-in two resident bedrooms in different parts of the home,
-in one resident common area on every floor of the home, which may include a lounge, dining area or corridor,
-in every designated cooling area, and
-once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control practice program when the staff didn't assist residents with their hand hygiene before a meal.

Inspector #211 observed that two staff members didn't assist residents with hand hygiene when entering one of unit's dining room prior their meal. Interviews with a Registered Nursing Staff and a PSW stated that resident's hands were sanitized in their bedroom prior coming to the dining room. Interview with the Dietary Manager stated that the residents' hands must be sanitized at the entrance of the dining room prior their meals, not in their room.

Sources: Inspector #211's observation. Interviews with two staff members. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control practice program when the staff assist residents with their hand hygiene before a meal, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's written record was maintained regarding monitoring sheet.

Review of a resident's progress notes written by a Registered Nursing Staff on a day, indicated that an identified Observation System sheet was started.

Interviews with RAI Coordinator and DOC stated that the resident's monitoring sheet was placed in the resident's room and the sheet was destroyed by the resident.

As such, since the resident was able to destroy the monitoring sheet kept in the resident's room and the licensee was unable to locate the monitoring sheet, the licensee has failed to ensure that the resident's written record was maintained.

Sources: Review of a resident's progress notes and an identified Observation System sheet. Interviews with RAI Coordinator and DOC. [s. 231.]

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 residents written record is maintained, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to initiate and maintain droplet and contact precautions for a fully vaccinated, admitted resident while their polymerase chain reaction (PCR) test result was pending.

The COVID-19, Directive #3 for Long-Term Care Homes (LTCH) under the LTCH Act (LTCHA), 2007, states that the admission of a fully vaccinated resident, must be placed in isolation on droplet and contact precautions while their polymerase chain reaction (PCR) test result are pending. The precautions can be discontinued, when the negative test results are available.

A resident was admitted to the home on a day and the licensee didn’t follow the above Directive #3.

The DOC, two staff and the resident confirmed that the resident was not placed in isolation on droplet and contact precautions, upon their admission. The licensee received the negative PCR test results four days after the admission.

Staff did not comply with infection prevention and control practices as directed in the COVID-19, Directive #3 for LTCH under the LTCHA, 2007.

Sources: Interview with the Administrator, DOC, two staff and a resident. Review resident’s progress notes, vaccination documentation, and COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 and Infection Prevention and Control for Long-Term Care Homes, Summary of Key Principles and Best Practices Guide, December 2020. [s. 5.]

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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

Issued on this 19th day of August, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JOELLE TAILLEFER (211), MANON NIGHBOR (755)
Inspection No. / No de l’inspection :	2021_831211_0011
Log No. / No de registre :	019165-20, 019682-20, 007498-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 22, 2021
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
LTC Home / Foyer de SLD :	Manoir Marochel 949 Montreal Road, Ottawa, ON, K1K-0S6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Paul Beverley

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 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.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must comply with s. 6 (7) of the LTCHA, 2007.

Specifically, for all residents exhibiting responsive behaviors, the licensee shall:
- review and reassess the resident's plan of care related to responsive behaviors and update ineffective interventions to ensure the resident's identified needs are met;
- perform bi-weekly audits of the plan of care for at least 3 different residents to assess the effectiveness of the interventions aimed at addressing responsive behaviors; and
- document the audit results as well as the strategies implemented to effectively manage identified responsive behaviors.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident's container had fluid inside it, that they were monitored closely, and the resident didn't have access to an identified room at all times, as specified in the plan of care.

A resident was found on the floor, in the identified room, presenting with a specific medical condition.

The resident's plan of care stated, to make sure they did not have access to an identified room, to monitor them closely with 30 minutes checks and to provide them with a specific drinking container.

Three staff confirmed that one of the specific interventions was not put in place since they felt it would not be effective. One staff member said the DOC was informed that one of these specific interventions was not effective and received

permission to not follow the specific intervention stated in the plan of care. The staff said that the RAI-MDS Coordinator was aware of the ineffectiveness of the specific intervention. Two staff members confirmed that one of the resident's interventions was not put in place. One staff member had no recollection if the resident had accessibility to another intervention put in place. Another staff member stated that they saw the resident going into the identified room before going to another unit, 15 minutes prior a staff member calling upon them urgently, when resident was discovered. When one of the staff members arrived on the scene, resident was on the floor, in the identified room and passed away thereafter.

Subsequently, not complying to the resident's responsive behavior and interventions as specified in their plan of care, permitted resident access to the identified area, placing them at risk to experience a medical condition secondary to their responsive behavior.

Sources: Resident's plan of care, progress notes, Hospital Discharge Summary Report, laboratories report and interviews with three staff members [s. 6. (7)]

An order was made by taking the following factors into account:

Severity: The resident had access to an identified room. There was actual risk of harm to the resident because the resident was found on the floor, in the identified room, presenting with a specific medical condition.
Scope: This non-compliance was isolated.
Compliance History: There was one written notification (WN), and one voluntary plan of correction (VPC), issued to the home related to different subsections of the legislation in the past 36 months. (755)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 17, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joelle Taillefer

Service Area Office /
Bureau régional de services : Ottawa Service Area Office