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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date July 13, 2022
Inspection Number 2022_1352_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☒ Other _____

Licensee
Southbridge Care Homes

Long-Term Care Home and City
Manoir Marochel, 949 Montreal Road, Ottawa, ON,

Lead Inspector
Julienne Ngo Nloga (502)

Inspector who Amended Digital Signature
Julienne Ngo Nloga
Digitally signed by Julienne Ngo Nloga
Date: 2022.09.21 12:09:36 -04'00'

Additional Inspector(s)
Joelle Taillefer (211)
Inspector (740837) Nathalie Lapointe was also present during the inspection

AMENDED INSPECTION REPORT SUMMARY

Finding was originally issued under O.Reg. 79/10 s. 92 and was corrected to reflect the correct legislative reference for O.REG. 246/22 s. 93.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 26, 27, 28, 29, 30, 2022, June 1, 2, 3, 6, 7, 8, and 9, 2022.

The following intake(s) were inspected:

- #020031-21 (CIS # 2867-000014-21) related to allegation of sexual abuse,
- #000398-22 (Complaint) related to staffing,
- #008656-22 (Complaint) related to care and services, housekeeping and maintenance, nutrition, and medication management,
- #019692-21 (Follow-up) related to fall and following plan of care,

Previously Issued Compliance Order(s)

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The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 6 (7)	2021_831211_0019	001	Joelle Taillefer (211)
Choose an item.				
Choose an item.				

The following **Inspection Protocols** were used during this inspection:

- Admission, Absences & Discharge
- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Palliative Care
- Prevention of Abuse and Neglect
- Quality Improvement
- Recreational and Social Activities
- Reporting and Complaints
- Resident Care and Support Services
- Resident Charges and Trust Accounts
- Residents' and Family Councils
- Residents' Rights and Choices
- Responsive Behaviours
- Restraints/Personal Assistance Services Devices (PASD) Management
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards
- Whistle-blowing Protection and Retaliation

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were *no findings of non-compliance*.

NON-COMPLIANCE REMEDIED: INFECTION PREVENTION AND CONTROL (IPAC)

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC #001 FLTCA, s. 23(4) remedied pursuant to FLTCA, 2021, s. 154(2)

The licensee has failed to ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection and control program.

In accordance to the regulation that came into force on April 11, 2022, O.Reg 246/22 s. 102 (15), the licensee shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 69 beds or fewer, al least 17.5 hours per week.

Rationale and Summary

On an identified date in May 2022, Inspector #211 observed that the home did not have an infection preventions and control (IPAC) lead whose primary responsibility was the home's infection and control program. Three days later, Inspector #211 noticed the licensee's Regional IPAC Staff was orienting a new IPAC lead.

A Registered Nursing Staff stated that in addition to normal duties, some functions assigned to an IPAC lead's role was added to their own Clinical Nurse role since mid-April 2022.

The Administrator stated that they have not have an IPAC lead since mid-April 2022.

The Licensee's Regional IPAC Staff confirmed that the new IPAC lead was hired as a full-time staff on a specific date in May 2022, in the home to accomplish their primary responsibility as the infection prevention and control program.

Sources: Inspector's observation. Interviews with registered staff, Administrator, IPAC Lead, Licensee's Regional IPAC, relevant home's record review. Joelle Taillefer (211)

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.REG. 246/22, s 102 (2) (B)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control program was implemented related to residents' hand hygiene.

In accordance with the Additional Requirement under 10.4 (h) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes dated April 2022, indicated that the licensee shall ensure to support residents to perform hand hygiene prior receiving meals and snacks.

Rationale and Summary
On an identified date, Inspector #502 reported to Inspector #211 their observation that during identified snack service when the residents were receiving their fluids; staff members did not assist the residents to have their hands disinfected prior to their snack.

The DOC validated that the resident's hands were not disinfected prior to all snack services.

Consequently, there was a potential risk to the residents' health and safety when the staff members did not support residents to perform hand hygiene prior receiving their snacks.

Sources: Inspector's observation, Interview with DOC. Joelle Taillefer (211)

WRITTEN NOTIFICATION ACCOMODATION SERVICES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCHA, 2021 s.19 (2) (A)

The licensee has failed to ensure that, the home, furnishings and equipment were kept clean and sanitary.

Rationale and Summary
A resident reported that the flooring in their shared washroom was black with unknown substance for several weeks in two months period.

On an identified date, the inspector noted a gap between the tiles from wall to wall. That gap was uncleaned and filled with dried black matter. This was brought to a staff member's attention.

The Housekeeping Assignment Sheet outlined Deep Cleaning Routine that should be completed approximately every 45 days. It indicated that the floor cleaning includes wiping the baseboards then to auto scrub entire floor area.

A review of the Deep cleaning calendar for three months period, showed that the resident's room and washroom were scheduled for a deep cleaning on two different dates within that period of time.

In an interview, a staff indicated that the floor was not cleaned during a specified weekend, as evidence by the dirt accumulated around the edge. They stated that the black mark on the floor was dried dirt. The staff indicated the accumulated matter in the crack should be scraped off during deep cleaning.

This was brought to the Executive Director (ED)'s attention. They directed that staff to scrub and clean the floor immediately.

Consequently, there was a potential risk to the resident's wellbeing as their environment was not cleaned as per deep cleaning schedule.

Sources: Inspector's observation. Interviews with a resident, staff, and ED. Review of deep cleaning schedule. [502]

WRITTEN NOTIFICATION ACCOMODTION SERVICES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCHA, 2021 s.19 (2) (c)

The licensee has failed to ensure that the home, furnishings, and equipment were maintained in a safe condition and in a good state of repair.

Rationale and Summary

1. A resident reported that their washroom floor was black with unknown substance.

On two different dates, the tiles on the washroom floor were observed with dark brown stains from the washroom's door up to the sink. The baseboard tiles were unglued from the wall. Some flooring was missing by the washroom's door.

The ED indicated that the resident raised a concern about the washroom. The Licensee's Regional Director checked that washroom and directed the home to replace the flooring immediately.

A staff indicated that the DOC informed them in April 2022 that the washroom floor in the identified room needed to be repaired.

At the time of this inspection, the flooring in the bathroom was not kept in a good stated of repair.

2. In May 2022, the Inspectors observed that the three quarter (¾) of the sidewalk left of the main entrance of the building was uneven and some parts of the sidewalk was cracked.

The ED acknowledged that the sidewalk / ramp was uneven. The ED stated that residents who can manage the sidewalk use it when they are leaving or coming from outings. Otherwise, residents should use the smooth surface on the road along site the parking lot.

3. Part of the overhead covered porch, above the smoking area, was noted to be damaged and a piece of concrete was hanging down from it.

Review of an email provided by the ED indicated that the damage on the overhead covered porch occurred in October 2018 and the insurance approval to cover the damage in March 2020.

The ED indicated that the repair of the damage on the overhead covered porch was based on the procurement and the availability of staff.

Both the uneven and cracked sidewalk and the damaged overhead covered porch were potential risk of injury to residents and others coming into the home.

Sources: Interview with a resident, relevant staff and ED, Inspector's observations, review of maintenance audit. [502]

WRITTEN NOTIFICATION ACCCOMODATION SERVICES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: OREG 246/22, s.93 (2) (d)

Finding was originally issued under O.Reg. 79/10 s. 92 and was corrected to reflect the correct legislative reference for O.REG. 246/22 s. 93.

The licensee has failed to ensure that procedures were developed and implemented for, addressing incidents of lingering offensive odours.

Rationale and Summary

On two different dates, two staff members confirmed that a resident's shared washroom had a lingering offensive odour of urine. One staff indicated that the washroom was cleaned one to two times per day.

On another day, a resident stated that there was a lingering offensive odour of urine in the shared washroom since the admission of the co-resident who exhibited an identified behaviour and that made them uncomfortable.

In an interview, the ED stated that the process in place to address lingering offensive odours in the home included the use of scents (spray, odour scent) available in the home, and frequent cleaning. The ED mentioned that staff clean twice a day during the day shift. When the Inspector's brought the concern to the ED's attention, they placed the odour scent in the washroom and directed housekeeping staff to check the washroom regularly.

The home did not address incidents of offensive odours in a shared bathroom when the co-resident presented with specified behaviours.

Sources: Inspector's observations. Resident, staff, and ED interviews. [502]

WRITTEN NOTIFICATION WITH ABUSE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCA, 2007 s.20 (2) (D)

The licensee has failed to comply with the policy to promote zero tolerance of abuse and neglect of residents, shall contain an explanation of the duty under section 24 to make mandatory reports.

In accordance with O.Reg. 79/10 s.8 (1) (b), the licensee is required to ensure that there is a policy that provide an explanation of the duty under section 24 to make mandatory reports.

Specifically, staff did not comply with the policy "titled "Zero Tolerance of Resident Abuse and Neglect: Response and reporting" dated January 2021 which was captured in the licensee's Zero Tolerance of Resident Abuse and Neglect Program.

Rationale and Summary

On a date in 2021, a resident reported to a staff that they were abused by a staff of the home.

Review of the Critical Incident System Report (CIS) showed that the alleged incident of abuse was reported to the Director two days after the resident brought it to the staff's attention.

Home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and reporting" revised in January 2021, under Reporting states that (1) any employee or person who becomes aware of an alleged, suspect or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. (2) The person reporting the suspect abuse will follow the home's reporting process and provincial requirements to ensure the information is provided to the home Administrator /designate immediately.

In an interview, the DOC indicated that when the allegation of abuse was brought

to their attention on the identified date in December 2021, two days after staff #119 was made aware of the alleged incident. They initiated the mandatory reporting on the same day and acknowledged Program staff #119 did not follow the home's reporting process.

Sources: Critical Incident Report System Report, home's policy "Zero Tolerance of Resident Abuse and Neglect: Response and reporting, and home's investigation notes. Staff and DOC interviews. [502]

WRITTEN NOTIFICATION *SKIN AND WOUND*

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.REG.79/10 *s. 50 (1)*

The licensee has failed to ensure that the skin and wound care program must, at a minimum, provide for the provision of routine skin care to maintain skin integrity and prevent wounds.

In accordance with O. Reg. 79/10, s. 8 (1). (b) Where the Act or this Regulation requires the licensee of a long-term care home to have, procedure, the licensee is required to ensure that the procedure, must be complied with.

Specifically, staff did not comply with the policy "Skin and Wound Program: Prevention of Skin Breakdown" revised in January 2021, which was captured in the licensee's Skin and Wound Program.

Rationale and Summary

A resident reported on a date in 2021, that a staff abused them. A review of the Head-to-Toe Skin Assessment completed two days after the alleged incident of abuse indicated that the resident had two light bruises on their left and right lateral face.

Review of document survey report indicated that the resident had a shower on identified date within the period of allege abuse. Under "every Shift skin observation" there was no documentation of skin observation on all shifts on that period in 2021, any documentation on day or night shift.

The home's policy titled "Skin and Wound Program: Prevention of Skin Breakdown #RC-23-01-01 revised in January 2021 under procedure stated that care staff daily on all shifts (1) observed resident's head to toe skin condition, including heel, elbows, back of head and other pressure points, during the provision of personal care. (2) Document altered skin integrity in Daily Record or electronic equivalent.

In an interview, the DOC stated that full skin assessment should be completed on the resident bath's day, and during care. Staff should document their observation every shift.

As a result, the resident skin assessment was not completed until two days after the alleged allegation of abuse.

Sources: Review of CIS, resident's care plan, skin assessment, Document Survey report, relevant home policy, resident, Staff and DOC interview. [502]

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.

- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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