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

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Amended Public Report (A1)

Report Issue Date October 28, 2022
Inspection Number 2022_1352_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
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.)

Long-Term Care Home and City
Manoir Marochel
949 Montreal Road, Ottawa, ON, K1K0S6

Lead Inspector
Joelle Taillefer (211)

Inspector who Amended Digital Signature
Joelle Taillefer
Digitally signed by Joelle Taillefer
Date: 2022.10.28 09:54:17 -04'00'

AMENDED INSPECTION REPORT SUMMARY

This inspection report was amended to remove information related to previously inspected and complied orders from the original licensee report #2022_1352_0002 issued on September 30, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 17, 18, 19, 22, 23, 24, 25, 26, 30, 2022 (in-site), August 29, 2022, September 19, 2022 (off-site).

The following intake(s) were inspected:

- Intake # 012580-22 (Complaint) related to Fall Prevention and Management, Resident Charges and Trust Accounts, Laundry Services, Personal items, Medication Management, Nursing and Personal Support Services.

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

- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Medication Management
- Resident Care and Support Services
- Resident Charges and Trust Accounts

WRITTEN NOTIFICATION – FALLS PREVENTION AND MANAGEMENT

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 54 (2)

The licensee has failed to comply with the policy to ensure that when a resident has fallen, the resident was assessed, and a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

In accordance with O. Reg. 246/22 s.11 (1) (b), the licensee of a long-term care home is required to ensure that when a resident has fallen, the resident was assessed, and the policy and procedures must be complied with.

Specifically, the staff did not comply with the policy #RC-15-01-01 “Fall Prevention and Management Program” Appendix 6 “Clinical Monitoring Record”, that indicated after a resident’s fall to monitor every hour x 4 hours then every 8 hours x 72 hours.

On a date in 2022, a resident while walking with a device, lost balance and fell hitting themself against a structure of the home. On that date, the resident’s post-fall assessments were not initiated and were not completed as their policy.

The Executive Director and a Registered Nursing Staff confirmed that the post-fall assessment was not initiated or completed as indicated in their policy.

As such, as the “Falls Management-Clinical Monitoring Record” was not initiated and completed as their policy, there was a potential risk that any change in the resident’s health condition would not have been identified.

Sources: Review of a resident’s health care records and the “Fall Prevention and Management Program” Appendix 6 “Clinical Monitoring Record”. Interviews with a Registered Nursing Staff and the Executive Director. [211]

WRITTEN NOTIFICATION - PLAN OF CARE

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

Non-compliance with: FLTCA, 2021 s. 6. (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspect of a resident's care collaborate with each other when the physiotherapist was unavailable, so that their assessments are integrated and are consistent with and complement each other in the assessment of the resident.

A resident sustained several falls within a period of days.

Review of the resident's health care records indicated that the staff members sent two referrals for mobility or seating devices and one referral for post fall assessment to the physiotherapy.

The physiotherapist stated being not available during that period of time. The physiotherapist stated as the physiotherapy referral did not indicate that the assessment was urgent, a referral to another physiotherapist colleagues was not organized.

Consequently, the resident was at risk of further falls, as the resident's mobility was not assessed by physiotherapy services.

Sources: Review of a resident's health care records and interview with the physiotherapist. [211]

WRITTEN NOTIFICATION – PLAN OF CARE

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

Non-compliance with: FLTCA, 2021 s. 6 (9) 1.

The licensee has failed to ensure that the provision of oral care and the hourly rounds set out in a resident's plan of care were documented.

Review of a resident's plan of care on a date in 2022, indicated that the resident had specific oral care needs.

The resident's Point of Care (POC) under oral care, indicated that a staff member did not document that the resident's oral care was provided for four days in 2022, during specific hours.

A staff member stated that the resident's oral care was provided, but it was not documented.

2.Review of a resident's health care records indicated that the resident sustained a fall on a specific date in 2022.

Resident's POC indicated that the hourly rounds were not documented for several identified hours.

The DOC stated that the hourly rounds were performed by the staff members but confirmed that the documentation was not completed.

As such, the resident's provision of oral care and the hourly rounds were not documented as set out in the resident's plan of care.

Sources: Review of a resident's health care records and interviews with a staff member and the DOC. [211]

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. Please include the inspection report # and the order or AMP #;
(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.