Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: January 23, 2023	
Inspection Number: 2022-1352-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: CVH (No. 4) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: Manoir Marochel, Ottawa	
Lead Inspector Manon Nighbor (755)	**Inspector Digital Signature** Manon Nighbor Digitally signed by Manon Nighbor Date: 2023.01.24 14:22:48 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 6, 7, 8, 9, 12, 2022

The following intake(s) were inspected:
• Critical Incident Intake (CIS): #00007223 [CIS: 2867-000009-22] and Complaint Intake #00013459 related to falls.
• Critical Incident Intake: #00009299 [CIS:2867-000011-22], Complaint Intakes #00014154 and #00010752 related to an unexpected death.

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

Rational and Summary:
The licensee's Fall Prevention Management Program includes as one of their fall prevention strategies; the 4 Ps, which addresses the resident's pain, positioning, prompting for toileting and having their needed possessions in reach, before the staff leaves the resident's room.

A multidisciplinary meeting, including the resident's family member, was held on a specific date, to address the resident's multiple falls. One outcome of the meeting was to add the 4 Ps to the resident's current fall prevention interventions plan of care.

However, the resident's written plan of care indicated that the 4 Ps had been cancelled. As a result, the 4 Ps were not included in the Point of Care tasks, therefore they were not implemented in the resident's plan of care, as planned.

Later that month, the resident had another fall, sustained a head injury, was assessed in hospital and required treatment. Several days after the resident's return to the home, the resident had a sudden change in their health status and passed away.

Not implementing the 4 Ps may have potentially increased the resident's risk of falls.

Sources: Interview with the Clinical Nurse Manager, staff member #113, Fall Prevention Management Program, Progress Notes, Plan of Care and Point of Care. [#755]