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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: December 5, 2025

Inspection Number: 2025-1352-0004

Inspection Type:
Complaint
Critical Incident

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21, 22, 23, 24, 27, 28, 30, 2025 and November 3, 4, 5, 6, 7, 10, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 2025

The following intake(s) were inspected:

- Intake: #00157952 (CIS #2867-000034-25) - An allegation of neglect of a resident
- Intake: #00159072 - A complaint regarding skin and wound care
- Intake: #00160828 and Intake: #00161758 - A complaint regarding skin and wound care

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

Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Reporting and Complaints
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The resident's Substitute Decision Maker (SDM) was not provided opportunity to participate fully in the development and implementation of the resident's plan of care for wound care.

Sources: Healthcare record, and interviews with Registered Practical Nurses (RPN), a Registered Nurse (RN), the Residential Assessment Instrument (RAI) Nurse, a Director of Care (DOC), and the Substitute Decision Makers.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the

policy is complied with.

The licensee's policy to promote zero tolerance of abuse and neglect of residents identified that staff members who are accused of abuse or neglect of a resident will be placed on a leave of absence pending investigation and if those staff members are Registered Staff then they will be reported to their regulatory authority as soon as possible and prior to the end of the investigation.

Registered staff members were interviewed as part of the investigation into an allegation of neglect and the licensee concluded their actions reflected a pattern of severe negligence in the care of the resident. None of the staff members were placed on a leave of absence pending investigation or were reported to their regulatory authorities.

Sources: Critical Incident Report, internal investigation documents, Zero tolerance of resident abuse, neglect and unlawful conduct policy, and interviews with Administrators and the Senior Nursing Consultant.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

Following an investigation into an allegation of neglect, a specified number of staff members actions were identified to reflect a pattern of severe negligence which

negatively impacted the health and safety of residents.

The identified staff members did not participate in the initial training session offered on wound care and only received training at a later date. Further, these staff members continued to work their regular shifts after the conclusion of the investigation before completing the licensee's disciplinary action.

Sources: Staff schedules, Human Resources documents, Critical Incident Report, staff training documents, and interviews with a DOC, and Administrators.

WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1)
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures.
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

As per Ontario Regulation (O. Reg) 246/22 s. 11 (1) (b), the licensee is to ensure that all required programs, including the pain management program, are complied with.

The Pain Management Program identified that PSW staff were to observe the

resident daily for pain, document in the care record and report pain to the Registered Staff. It also identified that a pain assessment should be completed on hospital readmission, and on sudden onset of worsened pain or onset of behaviours that could indicate pain.

Point of Care documentation and two PSWs identified the resident experienced pain on many shifts during a five month period. Two RPNs also identified that the resident experienced pain and identified that the resident had an as needed (prn) dose of a medication available to manage pain. The physician identified on two occasions that this medication should be provided prior to a specific care task. However, the prn dose of this medication was only administered five times during a four month period, despite the resident receiving this care task every three days. This medication was later discontinued without any additional pain management strategies put in place.

Sources: Pain Management Program, healthcare record, interviews with Personal Support Workers (PSW), RPNs, a RAI Nurse, and a DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but

not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The complaint response letter was not sent within 10 business days for a written allegation of neglect.

Sources: Complaint letter, response letter, and interviews with an Administrator and the Senior Nursing Consultant.

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The complaint response letter did not identify if the licensee was required to immediately forward the complaint to the Director and confirmation if this was completed.

Sources: Complaint response letter, interview with an Administrator.

WRITTEN NOTIFICATION: Licensees who reports investigations

under s. 27 (2) of the Act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 3. v.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The outcome of the internal investigation found a specified number of registered staff members were negligent in the care of the resident, however this was not stated in the Critical Incident Report.

Sources: Critical Incident Report, suspension notices, internal investigation documents, interviews with an Administrator, a DOC, and the Senior Nursing Consultant.

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Complete a review of the Pain Management Program and identify if any revisions are required.

2) Provide training to all Personal Support Workers and Registered Staff on the licensee's Pain Management Program. Pursuant to their role, the training should include, at minimum, verbal and non-verbal signs and symptoms of pain, responsibilities in monitoring for and reporting pain, documentation of signs and symptoms of pain, pharmacological and non-pharmacological management of pain, assessment of the effectiveness of pain management strategies, when the Physician and/or Nurse Practitioner should be notified, how to complete a pain assessment and when an assessment should be completed.

3) Complete a review of the licensee's policy to promote zero tolerance of abuse and neglect of residents, including the procedure for investigating and responding to allegations of abuse and neglect of a resident. Identify and complete any revisions required to ensure the safety of residents when an allegation of abuse or neglect has been made, during the investigation into an allegation of abuse or neglect, and what actions should be taken at the conclusion of an investigation.

4) Provide training on the licensee's policy to promote zero tolerance of abuse and neglect of residents to all Managers and any other staff members in a leadership position who would respond to an allegation of abuse or neglect of a resident.

5) Maintain a written record of everything required under sections (1), (2), (3) and (4), including the training materials, the date of the training and who attended the

training.

Grounds

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A weekly assessment of the wounds was not completed on six dates. As well, wound assessments on five dates identified the wound(s) had deteriorated and wound assessments on three dates identified additional signs and symptoms of possible infection. A review of the weekly wound assessment photographs with the DOC identified further signs of infection to one of the wounds on four dates that were not previously identified by the Wound Care Nurse.

An Enterostomal (ET) Nurse assessed the resident's wounds, however their recommendations for wound care were not ordered and therefore were not entered in the electronic record on two dates. The ET Nurse also identified in a recommendation to update them in two weeks with a photograph of the wound for follow-up, however this did not occur. As a result, two RPNs identified that they did not consistently provide care to all wounds as they would follow the directions on the electronic record which only directed care for one wound during this time period.

Two PSWs and two RPNs identified that the resident experienced pain most days. The Physician ordered an as needed medication and advised that this should be provided prior to a specific care task. This medication was only administered to the resident five times during a six month period despite the resident receiving this

specified care task every three days. The medication was later discontinued and there were no additional pain management interventions put in place.

The outcome of the internal investigation into neglect of the resident determined that the actions of four Registered Staff Members reflected a pattern of negligence. However, the staff members were only informed of this determination one month after the conclusion of the investigation and were able to continue working during that time without any additional training or supervision put in place.

Sources: Healthcare record, internal investigation documents, and interviews with PSWs, RPNs, the Wound Care Nurse, an RN, a DOC, Administrators, and the Senior Nursing Consultant.

This order must be complied with by January 30, 2026

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

COMPLIANCE ORDER CO #002 Skin and wound care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (1)
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
1. The provision of routine skin care to maintain skin integrity and prevent wounds.
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.
3. Strategies to transfer and position residents to reduce and prevent skin

breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.
4. Treatments and interventions, including physiotherapy and nutritional care. O. Reg. 246/22, s. 55 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Complete a review of the Skin and Wound Care Program. If any required revisions are identified during the review, ensure these revisions are communicated to all staff responsible for the Skin and Wound Care Program in the home.

2) Provide training to all Registered Staff and Personal Support Workers on the Skin and Wound Care Program. Pursuant to their responsibilities this should include, at minimum, the provision of routine skin care, how to monitor for and identify changes to the resident's skin integrity, how to monitor for and identify deterioration or signs of infection of a wound, how to complete a wound assessment using the licensee's weekly wound assessment tool, and how to provide treatment to wounds, including newly identified wounds and when there are changes to a wound.

3) Complete a weekly audit of the pressure injury wounds in the home to ensure that all requirements of the Skin and Wound Care Program are being met, including:

a) Required assessments and tasks for new wounds
b) Wound assessments are being completed weekly and signs of infection or deterioration of a wound are correctly identified
c) Referrals to the Registered Dietitian are completed when required
d) Communication with the Physician and/or Nurse Practitioner is completed when

required
e) Communication with the SDM is completed when required
f) Wound care orders are obtained and accurately entered in the electronic record
g) Wound care is being completed per the resident's plan of care

The audit shall be completed for a minimum of 4 weeks, and until consistent compliance is identified.

4) Take immediate corrective action if the weekly audit identified that a requirement of the Skin and Wound Care Program was not met. The corrective action should include which staff members were involved, what actions were taken and when they were taken, and if there was any negative effect to the resident.

5) Maintain a written record of all requirements under (1), (2), (3), and (4), including the training materials, the date of the training and who attended the training as required under section (2).

Grounds

As per Ontario Regulation 246/22 s. 11 (1) (b), the licensee is to ensure that all required programs, including the skin and wound care program, are complied with.

i. The Preventative Skincare policy identified that the Wound Care Nurse or a Registered Staff member was responsible for notifying the Substitute Decision Maker of any new or worsening wounds. The policy also identified that all homes were to have a wound care committee that was to meet monthly.

The resident's health record did not indicate communication with the SDM during a four month period regarding new or worsening wounds, despite new wounds

identified during this time period, wound assessments on three dates identifying deterioration of a wound, and wound assessments on two dates identifying increase in size of a wound.

The Wound Care Nurse stated there was not a wound care committee in place during this time period and that there wasn't regularly scheduled meetings with the DOC to review the wounds in the home.

ii. The Wound Management policy identified that a referral was to be made to the Registered Dietitian for any new wounds and any wounds that were worsening or had not improved within 14 days. In addition, the Physician and/or Nurse Practitioner was to be notified if the wound had not improved in 14 days and the Substitute Decision Maker (SDM) was to be notified regarding skin alterations and provide consent for treatment. The policy also identified that wound treatment orders were to be obtained from the Physician or Nurse Practitioner and entered in the electronic treatment administration record (e-TAR). Appendix 7, the Skin Issues Checklist, identified that a pain assessment was to be completed for all new wounds and that wounds were to be documented in the wound tracker.

During a six month period, the resident did not receive a referral to the Registered Dietitian related to their wounds, despite new wounds identified during this period and wound assessments identifying symptoms of worsening wounds. Further, there is no indication that the Physician, Nurse Practitioner, or SDM were notified of these instances of worsening wounds and treatment options. As a result, there were no orders for wound care obtained from the Physician or Nurse Practitioner which resulted in missing wound care orders in the electronic record for some of the resident's wounds.

A pain assessment was not completed for the new wounds identified during this

time period. Further, the Wound Care Nurse and the DOC identified that the wound care tracker was not being completed for any wounds during this time period.

Sources: Wound Management, Preventative Skincare, Registered Dietitian referrals and assessments, electronic treatment record, ET Nurse referrals and assessments, weekly wound assessments, progress notes, PSW documentation, interviews with PSWs, the Wound Care Nurse, the Registered Dietitian, a DOC, and the Senior Nursing Consultant.

This order must be complied with by January 30, 2026

COMPLIANCE ORDER CO #003 Skin and wound care

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), 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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Complete a review of the wound care practices in the home. At minimum, clearly identify who is responsible for completing the following tasks: weekly wound assessments; obtaining wound care orders; entering wound care orders into the electronic record; providing wound care; completing referrals to the Registered Dietitian and the Physiotherapist when required; completing a referral to the Enterostomal (ET) Nurse and when this should be completed; actioning recommendations made by the ET nurse; communicating with the Physician or Nurse Practitioner when required; communicating with the SDM when required.

If a wound care task is identified as the responsibility of a sole Registered Staff member, ensure there is a back-up plan in place to ensure this is completed in their absence.

2) Provide training to all Registered Staff on the wound care task responsibilities identified in section (1) and any back-up procedures in place.

3) Maintain a written record of everything required under (1) and (2), including the training materials, the date of the training and who attended the training.

Grounds

An assessment for each wound was required to be completed weekly using the Pressure Injury (PUSH) assessment in Point Click Care. However, an assessment was not completed for the resident's wounds on six dates.

Some of the weekly wound assessments over a six month period of time identified deterioration of the wounds and signs of possible infection, however there were no

changes made to the plan of care for wound care.

A referral was sent to the Enterostomal Therapist (ET) Nurse on two dates during this time period, however their recommendations for wound care were not entered into the electronic record. Further, for a five month period, there were no wound care orders in the electronic record for some of the wounds which resulted in two RPNs and an RN identifying that they did not always provide care to all wounds as this was not identified as a required task.

Sources: Healthcare record, internal investigation documents, and interviews with RPNs, an RN, the Enterostomal Therapist (ET) Nurse, a DOC, and the Senior Nursing Consultant.

This order must be complied with by January 30, 2026

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.