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: March 9, 2026

Inspection Number: 2026-1352-0001

Inspection Type:
Other
Critical Incident
Follow up

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): February 4-6, 9-13, 17-20, 23-27, 2026
The inspection occurred offsite on the following date(s): March 2-4, 2026
The following intake(s) were inspected:
Critical Incidents
- Intake #00155439 - CI #2867-000030-25 and intake #00160681 - CI #2867-000028-25- related to alleged resident to resident abuse.
- Intake #00165970 - CI #2867-000047-25 related to an acute respiratory infections (ARI) - Outbreak.
- Intake #00167492 - CI #2867-000001-26 Improper/Incompetent treatment of a resident by staff related to wound care.
- Intake: #00170407 - CI #2867-000014-26 Improper/Incompetent care of resident by staff related to improper transfer.
- Intake #00163654 - CI #2867-000044-25 related to fall of a resident with injury.
- Intake: #00170195 - CI #2867-000013-26, Intake: #00170196 - CI #2867-000012-26, and Intake: #00170197 - CI #2867-000009-26

Improper/Incompetent treatment of residents by a staff member related to Administration of drugs.

Other

- Intake #00165433 related to multiple care concerns for a resident.

Follow-up

- Intake #00158064 related to General requirements for programs: Maintenance.
- Intake #00164240 related to water temperatures.
- Intake #00164241 related to administration of drugs.
- Intake #00164242 related to the availability of supplies.
- Intake #00164243 related to general requirements for programs: Laundry services.
- Intakes #00164449 and #00164450 related to skin and wound care.
- Intake #00164451 related to duty to protect for a resident.

Previously Issued Compliance Order(s)

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

Order #002 from Inspection #2025-1352-0001 related to O. Reg. 246/22, s. 34 (1) 1.
Order #002 from Inspection #2025-1352-0002 related to O. Reg. 246/22, s. 96 (2) (g)
Order #001 from Inspection #2025-1352-0003 related to O. Reg. 246/22, s. 140 (2)
Order #003 from Inspection #2025-1352-0003 related to O. Reg. 246/22, s. 48
Order #002 from Inspection #2025-1352-0003 related to O. Reg. 246/22, s. 34 (1) 1.
Order #003 from Inspection #2025-1352-0004 related to O. Reg. 246/22, s. 55 (2) (b)
Order #001 from Inspection #2025-1352-0004 related to FLTCA, 2021, s. 24 (1)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #002 from Inspection #2025-1352-0004 related to O. Reg. 246/22, s. 55 (1)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

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 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

In accordance with O .Reg 246/22, s.11(1) b, the licensee shall comply with any required policy/program put in place, specifically related to the home's Skin and

Wound Care Management policy.

According to the home's policy titled Nurse Specialized in Wound, Ostomy and Continence (NSWOC) Referral and Follow Up Process-Await and Review, when wound care supplies for a required treatment recommended by the NSWOC nurse are not available, the NSWOC is to be notified.
During an interview, a staff member stated that they were aware that the wound care supplies required for the treatment recommended by the NSWOC nurse for the resident, were not available in the home. They continued with the previously ordered treatment without informing the NSWOC nurse of the unavailability of the recommended product on that day.

Sources: review of a resident's clinical records, Policy NSWOC Referral and Follow Up Process-Await and Review, interviews with staff members.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

After a resident had a fall with injury, the plan of care indicated that the resident required a bed alarm and a specified continence care products. The resident was not reassessed, and the plan of care was not reviewed when the resident's specified continence care product and the bed alarm set out in the plan was no longer

necessary.

Sources: Inspector's observation. Review of the resident's plan of care, progress notes, Distribution list continence care product. Interviews with staff members.

WRITTEN NOTIFICATION: Licensee must comply

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

Compliance was not identified with all sections of the compliance order for Ontario Regulation s. 55 (1) related to the skin and wound care program.

Specifically, section (3)(g) of the compliance order regarding the weekly audit including ensuring each resident's wound care was completed as per the plan of care, and section (4) regarding documented immediate corrective action that included which staff member was involved, what actions were taken and when, and if there was any negative effect to the resident.

The weekly audits of the wound care program conducted for a specified period, did not audit compliance with completing wound care as per the resident's plan of care. Further, the weekly audits identified areas for correction including missed referrals to the Registered Dietitian when required, missed communication with the Substitute Decision Maker (SDM) when required, and staff signing for wound care treatments when the required supplies were not available. However, the documentation did not include if immediate corrective action was taken including

which staff member received corrective action, what actions were taken and when, and if the resident experienced any negative effect.

Sources: Weekly wound assessments, disciplinary actions documents, internal meeting notes, interviews with the Administrator and the Senior Nursing Consultant.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001 Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History: O. Reg. s. 55 (1)

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by

the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 4.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
4. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

The long-term care home did not ensure that rules regarding locks on shower and washroom doors in the home, were complied with.
The locks on the west home area shower room, adjoining washrooms inside the tub/shower rooms for both home areas, and the washroom outside the chapel were not maintained so they can readily release the lock from the outside, as they did not have any key to unlock these doors in an emergency.

Sources: Observations of these doors locked that could not be released from the outside; interviews with staff member.

WRITTEN NOTIFICATION: Air temperature

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)

Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The long-term care home did not ensure that the tub and shower rooms in the south home area, were maintained at a minimum temperature of 22 degrees Celsius.
Two residents indicated they were cold when receiving specified baths. Temperatures taken during this inspection, were recorded at 19.1 and 19.5 degrees Celsius in both the tub and shower rooms in one of the residents' care areas. A staff member indicated the heaters required repair as the dials to turn up the heat in both tub and shower rooms in the resident care area were not functioning.

Sources: Observations of the resident care area and temperature readings taken; interviews with a resident and staff members; records reviewed of the air temperature logs for three months period by nursing staff.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

In accordance with O .Reg 246/22, s.11 (1) b, the licensee is required to ensure that written policy developed for maintenance program was complied with.

The home's Water Temperature Monitoring indicated that care staff are to calibrate all thermometers used for water temperatures as per the manufacturer's instructions on a weekly basis.
Two registered staff members had checked the water temperature once per shift in random at handbasins in resident bedrooms where residents access water. Both registered staff members reported that they have not calibrated the thermometer over the last three months, when they first began conducting these temperature checks. They failed to perform either the hot or cold calibration method required to verify thermometer accuracy at the start of each shift, contrary to the manufacturer's instructions.

Sources: Inspector's observation. Review of the home's Water Temperature Monitoring policy #RFC-02-17 revised December 2025, How to Use and Calibrate a Probe Thermometer, The Canadian Institute of Food Safety (CIFS). Interviews with staff members.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On a specified date, after a meal service, a staff member used unsafe transferring techniques when assisting a resident to transfer without the assistance of a second staff. The resident's plan of care required side-by-side transfer by two staff.

Sources: Observation of the resident transfer. Review of the resident plan of care and transfer logo. Interviews with staff members.

WRITTEN NOTIFICATION: Falls prevention and management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

A resident had a fall with injury on a specified date. A post fall assessment was not completed using the Post Fall Assessment and Huddle that is specifically designed for falls and outlined in the home's policy. The Point Click Care (PCC) at the time of inspection showed that the post fall assessment was overdue.

Sources: Resident progress notes, Post Fall Assessment and Huddle Form record. Interview with a staff member.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to

minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations.

The resident was known to display identified responsive behaviours including during care since their admission.
In two different on a specified dates, a resident displayed a specified responsible behaviours toward two residents, and they continued to display responsive behaviours toward other residents.
Steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents as the care plan did not identify specified behaviours that could potentially trigger such altercations.

Sources: A resident's progress notes and plan of care. Interviews with staff members.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with Addition Requirement 5.4 (K) under the Infection Prevention and

Control (IPAC) Standard for Long-Term Care Homes (April 2022, revised September 2023), the policies and procedures for the IPAC program shall also address: IPAC policies for housekeeping, laundry, cleaning, and disinfecting.

On an identified date, staff members did not implement the home's Handling of Clean and Soiled Linen policy after providing continence care to two residents. Both staff did not handle soiled linen and residents' personal clothing as if they were contaminated and did not bag and put them into laundry carts at the point of care. Instead, they put the soiled linen and residents' personal clothing in the general laundry bags located in the hallways. Both residents were in additional contact precaution.

Sources: Inspector's observations, IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023), home's Handling of Clean and Soiled Linen policy #10.29, revised on 26th of April, 2025, and interviews with staff members.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #011 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.

On an identified date, a resident exhibited specified responsive behaviours toward another resident. The home's policy required the Director of Care (DOC) with the participation of the Interdisciplinary Team to investigate and determine the root

causes of the incident. The DOC did not comply with the policy, as they did not complete the incident investigation form outlined in the home's written policy to promote zero tolerance of abuse and neglect of residents.

Sources: Incident Investigation, Reporting, Response and Mitigation #RFC-04-01 revised August 2025, CIS and progress notes. Interviews with a resident and a staff member.

WRITTEN NOTIFICATION: Requirements relating to the use of a PASD

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 120 (1)
Requirements relating to the use of a PASD
s. 120 (1) Every licensee of a long-term care home shall ensure that a PASD used under section 36 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained.

A resident's plan of care indicated that a resident used a specified personal assistance services device (PASD) to enhance positioning and offload pressure. The resident's PASD was not removed as soon as it was no longer required to provide such assistance, which was observed during a meal and a snack service on two different dates.

Sources: Meal and snack service's observations. Review of a resident's plan of care. Interviews with staff members.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

On an identified date, a medication cart was observed to be unlocked and unattended in a resident care area. A registered staff member indicated that the medication cart should have been locked when not in use.

Sources: Observation, interview with the registered staff member.

WRITTEN NOTIFICATION: Administration of drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

On an identified date, during a meal service, a registered staff member, did not administer the medications to seven residents, when they left their medication cups on the dining room table. One resident had severe cognitive impairment, and the second resident had an identified controlled substance included in their medication. Five residents had moderate cognitive impairment, and they required cues or

supervision at all times.

Sources: Observation of the medication administration. Review of residents' electronic Medical Administration Record (eMAR), and Minimum Data Set-Resident Assessment Instrument (MDS-RAI). Interviews with staff members.

COMPLIANCE ORDER CO #001 Doors in a home

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Ensure the west home area door leading to a stairwell to the basement has a closing mechanism that functions to engage the door lock.
b) Ensure regular verification and testing of this door is in the home's maintenance care system, to ensure this closing mechanism is functioning at all times.

Grounds
The stairwell door in a resident's home area was not kept closed and locked. On an identified date, the inspector observed that a stairwell door was not locked. The

Environmental Services Manager (ESM) indicated that this door was equipped with a self-closing mechanism to lock the door. A week later, the same stairwell door's self-closing mechanism was not functioning to engage the lock on this door.

Sources: Observations of the west home area stairwell door to a home area; interviews with the regional Director for Southbridge, the regional Environmental Services Consultant for Southbridge and the ESM.

This order must be complied with by March 27, 2026

COMPLIANCE ORDER CO #002 Responsive behaviours

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that, when two residents demonstrate responsive behaviours, all parts of the BSO-DOS data collection sheet are completed including data collection, analysis and planning to meet the residents' needs.

Grounds
A - Behaviours Support Ontario-Dementia Observation System (BSO-DOS) was initiated on identified dates, as a strategy for a resident's specified responsive

behaviours. The Part 3 BSO-DOS data collection sheet, which was required to support analysis and planning, was not completed. As a result, the strategy developed for the resident demonstrating specified behaviours were not fully implemented because the care plan did not include an analysis of the data obtained through BSO-DOS monitoring.

Sources: BSO-DOS data collection sheets, a resident's progress notes. Interview with a staff member.

B - BSO-DOS was initiated on an identified date, as a strategy for a second resident's responsive behaviours. The Part 3 BSO-DOS data collection sheet, which was required to support analysis and planning, was not completed. As a result, the strategy developed for the second resident demonstrating responsive behaviours were not fully implemented because the care plan did not include an analysis of the data obtained through BSO-DOS monitoring.

Sources: BSO-DOS data collection sheets, a resident's progress notes. Interview with a staff member.

This order must be complied with by March 27, 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.