



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection  
prévue le Loi de 2007 les  
foyers de soins de longue**

**Health System Accountability and Performance**

**Division**

**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé**

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<b>Date(s) of inspection/Date(s) de l'inspection</b>	<b>Inspection No/ No de l'inspection</b>	<b>Type of Inspection/Genre d'inspection</b>
May 26, Jun 2, 2011	2011_036126_0005	Critical Incident
<b>Licensee/Titulaire de permis</b>		
1663432 ONTARIO LTD. 2212 GLADWIN CRESCENT, UNIT A-9, SUITE 200, OTTAWA, ON, K1B-5N1		
<b>Long-Term Care Home/Foyer de soins de longue durée</b>		
MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6		
<b>Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs</b>		
LINDA HARKINS (126)		
<b>Inspection Summary/Résumé de l'inspection</b>		

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Clinical Day Charge Nurse, the Nursing staff and the Activity staff.

During the course of the inspection, the inspector(s) reviewed the resident's health care records, observed both residents and reviewed the Home education schedule for last year.

The following Inspection Protocols were used in part or in whole during this inspection:

**Prevention of Abuse, Neglect and Retaliation**

**Responsive Behaviours**

**Findings of Non-Compliance** were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

<b>Definitions</b>	<b>Définitions</b>
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.)

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following subsections:**

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

**Findings/Faits sayants :**

1. May 26, 2011 - 13:38 - Discussion with the Clinical Nurse and the Activity Staff and no education /training was given to staff regarding zero tolerance of abuse in 2011.

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits sayants :**

1. Jun 02, 2011 - 14:22 - The incident of abuse involving two residents was not reported to the police.

Issued on this 7th day of June, 2011



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Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

A handwritten signature in black ink, appearing to read "Hauken".