



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

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

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

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch

Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, K1S-3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ème</sup> étage  
OTTAWA, ON, K1S-3J4  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 5, 2014	2014_284545_0005	O-000974- 13	Critical Incident System

**Licensee/Titulaire de permis**

1663432 ONTARIO LTD.  
2212 GLADWIN CRESCENT, UNIT A-9, SUITE 200, OTTAWA, ON, K1B-5N1

**Long-Term Care Home/Foyer de soins de longue durée**

MANOIR MAROCHÉL  
949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

ANGELE ALBERT-RITCHIE (545)

**Inspection Summary/Résumé de l'inspection**



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

**This inspection was conducted on the following date(s): February 19 and 20, 2014**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Clinician, RAI Coordinator, a Registered Nurse (RN), several Registered Practical Nurses (RPN), several Personal Care Workers (PSW), a visitor, Resident #001 and other residents.**

**During the course of the inspection, the inspector(s) reviewed Resident #001's health record, the Home's Abuse and Neglect Prevention Policy and Program, effective March 12, 2012/reviewed March 2013, Resident's Bill of Rights In-Service Attendance Sheet completed by staff that attended training on May 21, 2013 and April 10, 2012, an internal employee incident report dated September 30, 2013, an internal Concerns and Complaints report completed on October 8, 2013, observed care/services provided to residents and interactions between staff and residents.**

**The following Inspection Protocols were used 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**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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. 24. Reporting certain matters to Director**



Specifically failed to comply with the following:

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with the LTCHA, 2007, S.O. 2007, Chapter 8, s. 24 (1), in that the licensee did not report immediately to the Director the alleged physical abuse.

During an interview with the Administrator he indicated that he was made aware on a specific date in October 2013 by an individual that witnessed Staff S110 slap Resident #001 while providing care on a specific date in September 2013. The Critical Incident Report was completed and submitted to the Director on a specific date in October 2013; three days after the Administrator and Director of Care had reasonable grounds to suspect the alleged physical abuse. [s. 24. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in ensuring that a person who has reasonable grounds to suspect any alleged, suspected or witnessed abuse needs to immediately report to the Director, to be implemented voluntarily.***



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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

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

**s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:**

- 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).**
- 2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).**

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**Findings/Faits saillants :**



1. The licensee failed to comply with O.Reg 79/10 s, 221.(2) in that the licensee did not ensure that all staff who provide direct care to residents receive annual training on abuse recognition and prevention as per the LTCHA, 2007, S.O. 2007, Chapter 8, s. 76 (7).

The Administrator confirmed that he was responsible in providing training on the Residents Bill of Rights including information on abuse recognition and prevention program.

In reviewing the In-Service Attendance Sheets for Residents' Bill of Rights training offered in 2012 and 2013, it is noted that Staff S110 did not participate in such training. The Director of Care confirmed during an interview that Staff S110 did not attend the annual training that was provided to all staff in the past two years. [s. 221. (2)]

2. It is indicated in the Home's Abuse and Neglect Prevention Policy and Program, on page 9 of 10 that at least once a year, all employees are responsible to participate in a review of the abuse and neglect prevention program.

In an interview with the Administrator he indicated that on a specific date in May 2013, 26% of the staff attended the Residents' Bill of Rights training.

In an interview with the Director of Care, it was indicated that the date and time for the training session of a specific date in May 2013 was posted several weeks in advance and that it was the responsibility of the staff to attend. The Director of Care indicated that the staff that did not attend training were expected to complete self-learning by reading the policy, however as the status of the self-learning completion was not monitored, the Director of Care was unable to provide evidence that all staff received training on abuse and neglect prevention program at least once a year. [s. 221. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in ensuring that all staff participate in abuse recognition and prevention training at least once per year, to be implemented voluntarily.***



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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

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

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**

**(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and**

**(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

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**Findings/Faits saillants :**

1. The Licensee failed to comply with O.Reg 79/10 r.97.(1)(b), in that the licensee did not ensure that the resident's substitute decision-maker was notified within 12 hours upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of Resident #001.

In a progress note dated on a specific date in October 2013 it is indicated that Resident #001's Power of Attorney was contacted of the alleged physical abuse by a staff member which occurred on a specific date in September 2013.

During an interview with the Director of Care, it was indicated that Resident #001's Power of Attorney was indeed notified of the alleged physical abuse on a specific date in October 2013, three days after she became aware of the incident. [s. 97. (1) (b)]

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Issued on this 5th day of March, 2014

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

*Angèle Albert Ritchie*