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
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Original Public Report

Report Issue Date: February 16, 2024	
Inspection Number: 2024-1312-0001	
Inspection Type: Critical Incident	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Cobden, Cobden	
Lead Inspector Dee Colborne (000721)	**Inspector Digital Signature** Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2024.02.20 13:16:38 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5, 6, 7, 8, 9, 12, 2024

The following intake(s) were inspected:

- Intake: #00094320 -Resident to resident verbal abuse.
- Intake: #00098925 -Written complaint to home regarding nourishments, hydration and skin integrity.
- Intake: #00100292 -Alleged neglect by staff to a resident.
- Intake: #00101659 -Alleged staff to resident neglect.
- Intake: #00102507 -Resident to resident verbal/emotional abuse.
- Intake: #00105841 - Fall of resident resulting in an injury.

The following intake(s) were completed during this inspection:

- Intake: #00096854 -Complaint of general neglect and abuse at the home.

- Intake: #00100091 -Fall of a resident resulting in being sent to hospital.
- Intake: #00102565 -Unwitnessed fall resulting in injury

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care- Clear directions to staff

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a written plan of care provides clear directions to staff and others who provide direct care to the resident. Specifically, to ensure that a resident's plan of care gives clear direction to staff in regards to continence

care.

Rationale and Summary:
Record review of a resident's written plan of care in regards to toileting identifies they are to be checked twice overnight and given a bedpan at night if required.

Record review of a resident's progress notes identify that they were left on the bedpan on a specified date in October, 2023 for a specified period of time.

Record review of homes investigation notes in regards to a resident being left on the bedpan for a specified length of time on a specified date in October 2023, confirm that staff did leave the resident on the bedpan for a specified length of time.

During an interview with the resident on a specified date in February 2024 they stated that they were left on the bedpan for a period of time and that they felt the staff had forgotten about them.

Interview with a Registered Nurse (RN) confirms that a resident was left on the bedpan for a specified amount of time in October 2023.

Interview with the Director of Care (DOC) confirms that a resident was left on the bedpan by staff for a specified amount of time in October 2023 and that staff should have gone back to check on the resident.

Failure to ensure clear direction are on a resident's written plan of care, increases the risk for staff leaving the resident on a bedpan longer than necessary which could lead to skin integrity issues

Sources: Resident's written plan of care, progress notes, homes investigation notes,

interviews with a resident, an RN, DOC and other staff.
[000721]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A) The licensee failed to ensure that the plan of care was complied with. Specifically, a resident's written plan of care regarding falls prevention interventions were not followed which resulted in a significant injury to the resident.

Rationale and Summary:
Review of a resident's written plan of care specifies that a specified type of safety equipment is to be on and functioning and promptly answered, and that intentional care rounds are to be completed every hour for safety and to anticipate resident's needs.

Personal Support Worker's (PSW) documentation for checking the specified safety equipment every hour was not completed on a specified date in January 2024. The PSW documentation for separate hourly purposeful rounds were all documented at one specific time for every hourly check.

Review of the home's investigation notes identified that staff did not follow the written plan of care for a resident in regard to ensuring the safety equipment was on

and functioning as well as the PSW not checking on the resident when they were calling out for help.

Review of the resident's post fall assessment identifies that the safety equipment be was not in place at the time of the fall.

Interview with a PSW and the Registered Practical Nurse (RPN) identified that the resident did not have their safety equipment on and functioning and it was turned off on a specified date in January 2024.

Interview with the DOC confirmed that the PSW documented all care rounds at one specific time for all hourly checks. They confirmed that documentation for January 2024 to check for safety equipment to ensure it was in place was not documented.

Failing to ensure that staff comply with the resident's written plan of care in regards to falls prevention strategies, increases the risk for the resident to sustain further injury.

Sources: Resident's written plan of care, post falls assessment, PSW documentation, interviews with PSW, RPN, DOC and other staff.

[000721]

B)The licensee has failed to ensure that the written plan of care is complied with. Specifically, staff did not comply with a resident's written plan of care regarding bathing.

Rationale and Summary:

Review of a resident's written plan of care in regards to bathing identifies that they are dependent on two staff for all aspects of bathing.

Review of a resident's progress notes identified that the resident had been left alone in the bathing transfer equipment by a PSW and the resident was found by staff to have slid out of the bathing transfer equipment.

Review of home's internal investigation notes identified that PSW did not comply with the resident's written plan of care for two staff to bath the resident and did not apply the safety equipment and left the resident alone in the tub room.

Interview with a PSW confirmed that they transferred the resident on their own and did not place the lap belt on the resident during the bath.

Interview with the DOC confirmed that the PSW did not follow the plan of care for the resident when giving them a bath. They did not apply the lap belt and did not perform the bath with two staff and left the resident in the tub room unattended a few times.

Failure to ensure the written plan of care is complied with increases the risk to the resident to be safe and free from harm or injury.

Sources: Resident's written plan of care, progress notes, homes investigation notes, interviews with PSW#101, DOC and other staff.

[000721]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that, for two residents demonstrating responsive behaviors, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Rationale and Summary:

Review of a resident's progress notes identified several incidents of verbal aggression towards another resident prior to the alleged verbal abuse on a specified date in November 2023. No referrals were made to the Behavioural Support of Ontario staff, (BSO), so that an assessment could be made in regards to a resident's verbal behaviours.

Review of both resident's Dementia Observation Tool (DOS) completed during a period in November 2023 identified that the DOS was not reviewed in its entirety by BSO staff. The section of what does the data reveal, possible contributing factors along with next steps was not completed.

Review of BSO binder in the meeting room that staff utilize identified that neither

resident were on the BSO caseload.

During the interview with an RPN, they confirmed there was a verbal altercation between two residents. They confirmed that should new behaviours be noted, a BSO referral will be completed via a BSO book, and they will follow up and leave a BSO sheet for staff to follow in the binder.

During an interview with a BSO staff they confirmed that there wasn't a clear-cut system process for BSO referrals. It was word of mouth and sometimes would get entered in Point Click Care (PCC). Follow up documentation was sometimes in PCC, and also via notes that were kept by BSO staff. They stated that both residents were on the BSO caseload prior to the incidents in August and November 2023 and that the Social Worker was working with the residents more than BSO.

Interview with another BSO staff confirmed they did not complete the November 2023 DOS analysis for the two residents as they were just learning about BSO and didn't know how to complete that part.

Interview with the DOC confirmed that referrals to BSO previously were word of mouth but are now to be completed via PCC and the expectation is BSO staff document assessments and follow ups and any interventions. Tips are noted in a binder in the meeting room for staff to utilize.

Failure to ensure that actions taken to respond to the needs of residents via assessments, reassessments and to document these interventions, places risk of staff not knowing how to manage residents' behaviours.

[000721]

WRITTEN NOTIFICATION: Police Notification

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service 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. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident. Specifically, the home did not immediately notify the appropriate police service regarding resident-to-resident alleged abuse.

Rationale and Summary:

Record review of a resident's progress notes identify that an incident of verbal abuse occurred from another resident on a specified date in November 2023. Progress notes further state that the police were not contacted until the next day, and attended the home that same day to speak to the resident as this was the second incident of alleged verbal abuse.

Record review of the homes investigation notes identify that the police were not called about the incident until the day after the alleged incident on a specified date in November 2023 and came in the same day and had a discussion with the resident.

Interview with the DOC on a specified date in February 2024 confirmed that the police were not called about the incident until the day after the alleged incident on a specified date in November 2023 and is aware that the police are to be notified immediately.

Failure to ensure the police are notified immediately of an alleged abuse, places increased risk for residents in regards to appropriate follow up and action required to stop the abuse.

Sources: Resident's progress notes, homes investigation notes, interview with DOC and other staff.

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