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: August 17, 2023	
Inspection Number: 2023-1214-0004	
Inspection Type: Critical Incident System	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Marmora, Marmora	
Lead Inspector Darlene Murphy (103)	**Inspector Digital Signature** Darlene Murphy Digitally signed by Darlene Murphy Date: 2023.08.17 09:21:41 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 10, 11, 14, 15, 2023.

The following intake(s) were inspected:

- Intake: #00092445 (CI: 2718-000016-23) -Improper/Incompetent treatment of a resident that resulted in a fall,
- Intake: #00092974 (CI: 2718-000018-23) -Failure to follow policy for drug disposal and destruction,
- Intake: #00093248 (CI: 2718-000020-23) and Intake #00094275 (CI: 2718-000021-23)-alleged incidents of resident to resident sexual abuse.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Persons who had reasonable grounds to suspect resident abuse involving a resident, failed to immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary:

A resident was observed touching another resident inappropriately on two occasions. A Personal Support Worker (PSW) redirected the residents and reported the incident to the Registered Practical Nurse (RPN). The RPN did not report the incident to the charge nurse as they stated this behaviour had previously occurred and did not require additional reporting. Upon reviewing the twenty-four report on the following morning, the Director of Care (DOC) reported the alleged incident of resident to resident abuse to the Director by submitting a critical incident.

On another date, a PSW observed another resident inappropriately touching the resident. The PSW redirected the residents and reported the incident to the RPN. The RPN stated they believed the charge Registered Nurse (RN) had also overheard the PSW's report and did not take further action. Another RN became aware of the alleged incident of resident to resident abuse during their oncoming shift report, but also failed to immediately report the incident despite knowing the incident was reportable. The DOC reported the alleged incident of resident to resident abuse to the Director by submitting a critical incident the following day.

Sources: CIS #2718-000020-23 and CIS #2718-000021-23 and interviews with staff members.
[103]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the fall prevention and management program.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure there are written policies for equipment used for safe resident transfers and that the policy is complied with.

Specifically, the home failed to comply with "Sling Use with Lifting Devices" last reviewed in March 2022, by failing to ensure two staff were present during the attachment of the sling to the lifting device, both staff participating in the lift, visually checked the placement of each sling loop to ensure proper positioning and both staff members verbally acknowledged the loops were properly secured prior to initiating the lift.

Rationale and Summary:

A resident was being transferred from the wheelchair to the bed using a mechanical lifting device. A PSW stated they had prepared the resident for bed and had attached the resident's sling to the lifting device. The PSW stated they then sought out a second person to complete the transfer into bed. The second PSW stated they entered the resident's room to assist with the transfer and found the resident already in the sling which was attached to the lifting device. The PSW stated they said "ready" and, using the remote, began lifting the resident out of the wheelchair. During the transfer, one loop from the left side of the lifting device detached and the resident fell and sustained injuries.

Sources: interviews with staff members, review of lifting/transfer policy and the resident health care record.
[103]

WRITTEN NOTIFICATION: Medication Management System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee failed to comply with their medication management system.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure there are written policies to ensure the accurate destruction and disposal of all drugs used in the home and that the policy is complied with.

Specifically, the home failed to comply with "Patch Disposal for Monitored Medications", last reviewed in July 2017, by failing to dispose of medicated patches in accordance with the policy.

Rationale and Summary:

During drug destruction, the pharmacist and the Director of Care (DOC) noted a total of five medicated patches were missing from the drug destruction box. The home investigated the missing patches and discovered some staff members were not following the patch disposal policy. Re-education was provided to all registered staff regarding the policy.

Sources: Interview with DOC, Critical incident #2718-000018-23 and the home's policy related to destruction of medicated patches.
[103]