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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Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: November 16, 2023	
Inspection Number: 2023-1214-0006	
Inspection Type: Proactive Compliance Inspection	
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: 2023.11.16 13:59:02 -05'00'
Additional Inspector(s) Cathi Kerr (641)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2023, and November 1-3, 6-9, 14, 2023.

The following intake(s) were inspected:

- Intake: #00100336 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home

Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure all doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

Rationale and Summary:

During the initial tour of the home, Inspector #103 identified two doors that were unlocked. The first door opened to an area where continence products were stored on the North hallway and the second door opened to a room with filing materials and various additional items at the top of the East hallway. Discussion was held with the Director of Care (DOC) who confirmed both doors should be locked.

The following day, Inspector #103 found the door leading to the storage of continence products was again found to be unlocked, and the door to the medication room was observed to be locked but ajar. The DOC stated the door frame to the medication room had been painted several times in the past which prevented the door from closing spontaneously and required staff to physically pull the door shut. The DOC stated the home was in the process of stripping the excess paint from the door frame and indicated an automatic style door lock would be installed on the room where continence products were stored.

Sources:

Inspector observations, interview with DOC. [103]