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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: January 4, 2024
Inspection Number: 2023-1214-0007
Inspection Type: Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care Marmora, Marmora

Lead Inspector	**Inspector Digital Signature**
Darlene Murphy (103)	Darlene Murphy Digitally signed by Darlene Murphy Date: 2024.01.11 10:42:16 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 18-21, 2023, and January 2-3, 2024.

The following intake(s) were inspected:

- Intake: #00098760, (CIS#2718-000027-23)- Resident fall that resulted in an injury,
- Intake: #00101654, (CIS#2718-000038-23)-Alleged incident of resident to resident abuse,
- Intake: #00100634, (CIS#2718-000032-23), Intake: #00100668, (CIS#2718-000033-23), Intake: #00101080, (CIS#2718-000035-23), Intake: #00101370, (CIS#2718-000036-23), Intake: #00101979, (CIS#2718-000039-23), Intake: #00102187, (CIS#2718-000040-23)-Alleged incidents of staff to resident abuse.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure the written policy to promote zero tolerance of abuse was complied with.

Rationale and Summary:

During a meal service, a staff member witnessed a Personal Support Worker (PSW) forcefully feeding a resident while the resident resisted. The staff member reminded the PSW the resident was able to eat on their own. Later in the meal service, the

PSW was observed placing their hands on the resident's shoulders to make the resident sit down. The staff member again intervened and reminded the PSW the resident was able to get up from the table as desired.

The staff member indicated they believed these actions constituted resident abuse and attempted to report the incident to the charge nurse before the end of their shift. The staff member stated the charge nurse was busy and the alleged incident was reported the following day.

The home's zero tolerance of abuse policy requires all staff to immediately report all suspected or witnessed incidents of resident abuse to the registered nurse.

Sources: Critical incident, interview with staff member, home's abuse policy. [103]