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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Licensee Report

Report Issue Date: July 9, 2024
Inspection Number: 2024-1242-0003
Inspection Type: Complaint Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care Arthur Nursing Home, Arthur

Lead Inspector	**Inspector Digital Signature**
Janet Groux (606)	Janet Groux Digitally signed by Janet Groux Date: 2024.07.09 08:16:56 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 31, June 7, 11-14, 19, 20, 2024
The inspection occurred offsite on the following date(s): June 19, 2024

The following intakes were inspected:

- Intake #00110222 regarding the home's Falls Prevention and Management Program
- Intake #00112719 regarding a change in a resident's condition
- Intake #00114335 regarding concerns about a resident's altered skin integrity of unknown cause.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (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.

The licensee has failed to ensure that the care provided to a resident which resulted in several altered skin integrity was reported when improper care was suspected.

Rationale and Summary:

A resident was identified with multiple altered skin integrity of unknown cause.

The Director of Care (DOC) said they suspected that the resident sustained the altered skin integrity when they displayed responsive behaviours during care. They said care should have never been provided to the resident when the resident was displaying responsive behaviours. They said that staff had used poor judgment

when they provided care to the resident.

Failure to report an incident where improper care was suspected may prevent the Director from being able to respond in a timely manner.

Sources: A resident's progress notes, skin assessments, the home's investigation notes, and an interview with the DOC. [606]