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 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca

# Original Public Report

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|---|---|
| **Report Issue Date:** November 29, 2022 | |
| **Inspection Number:** 2022-1312-0001 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** Caressant-Care Nursing and Retirement Homes Limited | |
| **Long Term Care Home and City:** Caressant Care Cobden, Cobden | |
| **Lead Inspector**<br>Susan Lui (178) | **Inspector Digital Signature**<br>Susan Lui Digitally signed by Susan Lui Date: 2022.11.29 15:53:35 -05'00' |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 25-28, 31, November 1, 2022.

The following intake(s) were inspected:

- Complaint Intake #00001799 regarding continence care and residents' rights and choices.
- Critical Incident System (CIS) Intake #00003482 [CI: 2827-000008-22] regarding a fall with injury
- CIS Intake #00003670 [CI: 2827-000009-22] regarding an unexpected death.

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

Falls Prevention and Management
Resident Care and Support Services
Infection Prevention and Control

Residents' Rights and Choices

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

**Rationale and Summary:**
A resident was at high risk for falls and had a history of falls with injury. The resident's plan of care indicated that they should have three pieces of falls prevention equipment in use when they were up in their wheelchair.

The resident was observed in their wheelchair in a common area of the home. The resident had one of the three required pieces of falls prevention equipment in use. A PSW was present completing documentation and monitoring the resident for safety. The PSW indicated that the resident should have the three required pieces of falls prevention equipment in use, and they did not know why they were not in use, as they were not assigned to the resident that day.

A second PSW indicated that they and a colleague had got the resident up and into the wheelchair that day. The PSW indicated that they believed the resident required only one type of fall prevention equipment when up in the wheelchair.

The Director of Nursing (DON) indicated that the resident should have three different types of fall prevention equipment in use when they are up in the wheelchair, as specified in the resident's plan of care.

As such, the licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This non-compliance put the resident at increased risk for a fall.

**Sources:** Observations of fall prevention interventions; review of a resident's medical health record; interviews with two PSWs and the DON.
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