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

Original Public Report

Report Issue Date: May 17, 2023

Inspection Number: 2023-1312-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Cobden, Cobden

Lead Inspector	**Inspector Digital Signature**
Emily Prior (732)	Emily Prior Digitally signed by Emily Prior Date: 2023.05.18 08:17:14 -04'00'

Additional Inspector(s)
Margaret Beamish (000723)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8, 9, 10, 12 and 15, 2023.
The inspection occurred offsite on the following date(s): May 11, 2023.

The following intake(s) were inspected:

- Complaint intake #00013562 related to bed rails, falls prevention management, and resident support services
- Complaint intake #00019130 related to prevention of abuse and neglect and resident bill of rights
- Intake #00019840 (CI 2827-000001-23) related to prevention of abuse and neglect and resident bill of rights
- Intake #00086064 (CI 2827-000003-23) related to falls prevention and management
- Intake #00086745 (CI 2827-000005-23) related to alleged staff to resident abuse

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

Resident Care and Support Services
Infection Prevention and Control

Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

The licensee has failed to ensure that an incident of alleged staff to resident abuse was immediately reported to the Director.

Rationale and Summary:
A Critical Incident (CI) report was submitted to the Director on a specified date in 2023, describing an incident of alleged staff to resident abuse. Personal Support Worker (PSW) #110 witnessed the suspected incident of staff to resident abuse on a date in April, 2023 but did not report the incident until nine days later. At that time, the Director of Nursing submitted a report to the Director.

There was risk to residents by not immediately reporting the suspected abuse as the alleged staff member was able to continue working with residents for the remainder of their shift that day, and any other scheduled shifts up until their removal from the Long-Term Care Home nine days later.

Sources: CI #2827-000005-23; investigation notes; resident electronic health care records; and interview with PSW #110, and DON #109.
[732]

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the falls prevention and management program regarding head injury assessments was complied with.

Rationale and Summary:
In accordance with O. Reg. 246/22 s. 53 (1) 1., the licensee has failed to ensure that a falls prevention and management program is developed and implemented in the home. Further, in accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee shall ensure that any program required under the Regulation is complied with.

The licensee's policy, Post Fall Head Injury Routine Procedure, states that all observations are to be recorded on Neurological Vital Signs Post Head Injury Form, HIR Form-Neurological Vital Signs Post Head Injury for 72 hours for all witnessed falls with head injury and unwitnessed falls.

Resident #004 experienced unwitnessed falls on two occasions in April, 2023. Post-fall assessments were completed for both falls. A Neurological Vital Signs Head Injury form was initiated for both incidents, but all assessments were not completed as per the parameters outlined on the form. The form for the first fall had two of fifteen assessments that were not completed and the form for the second fall had five of fifteen assessments that were not completed.

Director of Nursing (DON) #109 confirmed that the Neurological Vital Signs Head Injury form and the parameters for the assessments on the form should have been followed for unwitnessed falls. In addition, DON #109 stated that any refusals of those assessments from a resident would be documented in a progress note. No refusals of assessment from Resident #004 were documented in the progress notes related to the two falls.

The failure to comply with the Post Fall Head Injury Routine Procedure caused an increased risk of injury due to follow-up assessments not being completed and documented.

Sources: Post Fall Head Injury Routine Procedure, LTC-NURS-S 10-50.0; Neurological Vital Signs Head Injury forms; progress notes; interview with DON #109.
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