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: April 8, 2024

Inspection Number: 2024-1312-0002

Inspection Type:
Critical Incident

Licensee: Caressant-Care Nursing and Retirement Homes Limited

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

Lead Inspector	**Inspector Digital Signature**
Dee Colborne (000721)	Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2024.04.08 12:37:35 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 21, 22, 25, 26, 2024

The following intake(s) were inspected:
Intake: #00110335- Visitor to resident alleged emotional abuse.
Intake: #00110783- Unwitnessed fall resulting in significant injury
Intake: #00111042-Unexpected death of a resident.

The following intake(s) were completed:

- Intake: #00109103-Unwitnessed fall resulting in an injury.

Inspector #000811 was present as an observer during this inspection.

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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: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a written plan of care provides clear directions to staff and others who provide direct care to the resident. Specifically, to ensure that a resident's plan of care gives clear direction to staff in regards to monitoring the resident during visits with a specified family member

Rationale and Summary:

A Critical Incident report (CIR) submitted by the home to the Director on a specified date in February 2024, stated that staff were to provide close monitoring when a specified family member was in visiting.

Upon review of a resident's written plan of care and Kardex on a specified date in March 2024, it was noted there were no interventions listed for staff to provide close monitoring when a specified family member is visiting.

During an interview with a personal support worker(PSW), on a specified date in March 2024, they confirmed they were not aware they needed to monitor the resident during visits with a specified family member.

During an interview with the Director of Care (DOC) on a specified date in March 2024, they confirmed that staff were to monitor a resident closely when a specified family member visited and to be mindful of loud conversations, and to document when interactions occurred. They confirmed that they should have specified in the written care plan for this direction.

Failure to ensure that clear directions were noted on the written plan of care for staff to follow, increased the risk for not intervening in a timely manner.

Sources: CIR, resident 's written plan of care, interview with a PSW, DOC and other staff.
[000721]