

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: March 1, 2024	
Inspection Number: 2024-1214-0001	
Inspection Type: Critical Incident	
Licensee: Caessant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caessant Care Marmora, Marmora	
Lead Inspector Carrie Deline (740788)	Inspector Digital Signature
Additional Inspector(s)	

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20 - 23, 26, 2024

The following intake(s) were inspected:

- Intake: #00104245 - CI# 2718-000046-23 - Alleged Emotional abuse of a resident by staff.
- Intake: #00104273 - IL-20890-AH/CI# 2718-000047-23 - Alleged neglect of a resident by staff.
- Intake: #00105072 - CI# 2718-000050-23 - Acute Respiratory Infection (ARI) - Outbreak
- Intake: #00105778 - CI# 2718-000003-24 - Enteric - Outbreak
- Intake: #00108087 - CI# 2718-000005-24 - Alleged abuse of a resident by staff.

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The following Inspection Protocols were used during this inspection:

Infection Prevention and Control  
Prevention of Abuse and Neglect  
Reporting and Complaints

## 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 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented.

#### Rationale and Summary

Review of the point of care (POC) tasks documentation on a specific date noted omissions in documentation.

During interviews with the Inspector, staff confirmed care was to be completed and documented in Point Click Care (PCC).

During an interview with the Executive Director (ED) it was confirmed that the care

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was completed but not documented in PCC.

Failing to ensure that a resident's care had been documented, can increase the risk of uncertainty whether the toileting was completed, or not.

Sources: Review of documentation, care plan and kardex. Interviews with staff.

[740788]

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with requirement 10 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022 revised September 2023), the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). ABHR shall be easily accessible at both point-of care and in other common and resident areas, and any staff providing direct resident care must have immediate access to ABHR that contains 70-90% alcohol concentration. Also, the licensee shall also ensure that the hand hygiene program for residents has a resident-centered approach with options for

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residents, while ensuring that hand hygiene is being adhered to. The hand hygiene program for residents shall include: assistance to residents to perform hand hygiene before meals and snacks.

### Rationale and Summary

1. During an observation it was observed that hand sanitizer dispensers were missing from a number of residents rooms. During an interview with the IPAC Lead it was confirmed that hand sanitizer stations should be located at the resident's bedsides.

2. During an observation at the lunch service residents entered the dining room and did not perform hand hygiene either independently or with assistance of staff prior to receiving a meal or fluids. During an interview with the IPAC Lead it was confirmed that residents are to use the hand hygiene sanitizer located outside the dining room before they enter for meals. The IPAC Lead also confirmed that if the residents' are unable to perform hand hygiene independently that staff are to assist them.

The impact of this noncompliance is that a lack of hand hygiene using a HH that contains at least 70% alcohol increases the risk of disease transmission among residents and staff.

Sources:

Observations, interviews with DOC and IPAC Lead.

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## WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that the complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

### Rationale and Summary

A review of the complaint documentation provided by the LTCH indicated that a complaint was received from a complainant on a specific date.

In reviewing the letter or response to the complainant it was noted that the response was sent to the the complainant fifteen days later.

Failure to respond within 10 days to the complainant could mean the complainant is

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unaware of the outcomes of the investigation or next steps to escalate the situation, this could impede the health, safety, and well-being of the residents.

Sources: LTCH complaint documentation, and interview with Executive Director.

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