Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 12, 2024
Inspection Number: 2024-1136-0004
Inspection Type: Complaint Critical Incident Follow up
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care on Mary Bucke, St Thomas

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 23, 25, 26, 29 - 31, 2024 and August 1, 2024
The inspection occurred offsite on the following dates: July 24, 2024

The following intakes were inspected:

- Intake: #00111877 - CIS: 2627-000007-24 - Related to falls prevention and management
- Intake: #00116007 - Complaint related to food, nutrition and hydration
- Intake: #00116008 - Complaint related to food, nutrition and hydration
- Intake: #00116012 - Complaint related to food, nutrition and hydration
- Intake: #00116661 - CIS: 2627-000010-24 - Related to the prevention of abuse and neglect
- Intake: #00116794 - CIS: 2627-000011-24 - Related to the prevention of abuse and neglect
- Intake: #00116941 - Follow-up #: 1 - O. Reg. 246/22 - s. 12 (1) 1. i. - Related to safe and secure home

- Intake: #00116942 - Follow-up #: 1 - O. Reg. 246/22 - s. 12 (1) 3. - Related to safe and secure home
- Intake: #00119411 - CIS: 2627-000014-24 - Related to resident care and support services

Previously Issued Compliance Order(s)

The following previously issued Compliance Orders were found to be in compliance:
Order #001 from Inspection #2024-1136-0002 related to O. Reg. 246/22, s. 12 (1) 1. i.
Order #002 from Inspection #2024-1136-0002 related to O. Reg. 246/22, s. 12 (1) 3.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

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

Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee has failed to ensure that appropriate action was taken in response to a complaint related to the care of a resident.

Rationale and Summary:
A Critical Incident (CIS) report was submitted for a complaint the home received regarding the care of a resident.

Although an investigation into the complaint was initiated, documentation does not support that the investigation included a resolution or notification to the complainant and Power of Attorney (POA) of the outcome of the investigation.

The Executive Director (ED) acknowledged that the investigation was not completed as required.

There was no risk to the resident as a result of the noncompliance.

Sources: CIS: 2627-000011-24, the homes investigation notes and interview with the ED.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to make an immediate report to the Director regarding a resident's disclosure of abuse.

Rationale and Summary:
The resident disclosed to staff that they were subjected to abuse from another resident last year.

The ED stated that they were aware of the incident and was under the impression that the home had included the disclosure of the abuse in a CIS report that was submitted this year, related to another abuse incident involving the two residents.

Although there were three amendments to the initial CIS report, none of the amendments included the resident's disclosure of the past abuse.

The failure to immediately report the allegation of abuse to the Director, placed the resident at further risk for potential abuse.

Sources: Resident’s progress notes, CIS: 2627-000010-24, and interview with the ED.

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following

interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that staff complied with the home's falls prevention and management program when providing care to a resident.

Rationale and Summary:
According to the home's investigation notes and interviews with staff, the resident was not provided the care they required and sustained a fall with injury.

In addition, staff did not follow the home's post-fall procedures when providing care to the resident after their fall.

The staff members' actions impacted the resident, contributing to their fall and subsequent injury, and placed the resident at risk for increased pain and additional injury.

Sources: Interviews with staff, the home's investigation notes, CIS: 2627-000007-24 and the resident's progress notes.