

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

Public Report

Report Issue Date: November 14, 2025
Inspection Number: 2025-1040-0004
Inspection Type: Complaint Critical Incident
Licensee: Caessant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caessant Care Bourget, Bourget

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6, 7, 10, 12-14, 2025.

The following Critical Incident (CI) intake(s) were inspected:
-Intakes: #00157200/CI 1160-000012-25, #00160663 /CI 1160-000014-25, and #00161607/CI 1160-000016-25 related to Improper/Incompetent treatment or care of a resident.

The following complaint intake(s) were inspected:
-Intake: #00159344 related to a complaint regarding safe and secure home, and resident care and support services.

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

- Resident Care and Support Services
- Staffing, Training and Care Standards

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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 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

1) On a date in September 2025, a Personal Support Worker (PSW) left a resident in a tub room without staff supervision while they retrieved clothing from the resident's room. The resident's plan of care indicated that they require one staff member to assist during toileting and bathing.

Sources: Resident's health care record review, LTCH investigation notes, interview with staff.

2) On a date in October 2025, a PSW transferred a resident to the toilet without assistance of a second staff member. Shortly thereafter, the resident was left unattended on the toilet, during which time they fell. The resident's plan of care indicated that they require two staff members to assist during toileting and transfers.

Sources: Resident health care record review, LTCH investigation notes, interview with staff.

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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) 1.

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

On a date in October 2025, a staff member witnessed an episode of improper/incompetent treatment wherein a resident was briefly left unattended in a non-resident area by another staff member. This was not reported to the Director until the next day.

Source: Interview with staff and review of Critical Incident (CI) report.