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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: July 22, 2025

Inspection Number: 2025-1114-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Fergus Nursing Home, Fergus

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15 - 18 and 22, 2025

The following intake(s) were inspected:

- Intake: #00146278 and Intake: #00152818: Related to resident to resident altercations.
- Intake: #00148708 - Complaint related to concerns about missing belongings.
- Intake: #00151914 - Complaint related to care concerns.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

An altercation occurred between two residents resulting in a skin tear to one of the residents.

Sources: Resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a resident was transferred safely in their wheelchair when their foot was not on the pedal.

Sources: Resident's clinical records, interviews with staff and resident.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that interventions are implemented to minimize the risk of altercations and harmful interactions between residents.

Two residents with responsive behaviours were involved in a physical altercation. The plan of care was updated for one of the residents with an intervention to minimize the risk of altercations. The intervention was not implemented and a second altercation occurred approximately three months later.

Sources: Resident's clinical records, interviews with staff.