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
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: April 29, 2025

Inspection Number: 2025-1108-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Caressant-Care Nursing and Retirement Homes Limited

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15 -17, 23, 24, 25, 28,29, 2025

The following intake(s) were inspected:
-Intake: #00139178 - Follow-up #: 1 - O. Reg. 246/22 - s. 59 (b) CO#001 inspection # 2025-1108-0001
-Intake: #00142473 - ARI outbreak
-Intake: #00142506 - Allegation of abuse of a resident by co resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1108-0001 related to O. Reg. 246/22, s. 59 (b)

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

Infection Prevention and Control

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 abuse by another resident.

Sources: Medical record review of the residents, interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the need of a resident when they demonstrated responsive behaviours towards another

resident.

Sources: Review of the residents' medical records, Review of the home's Internal BSO Referral Policy, interview with staff.