

**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:** June 25, 2025

**Inspection Number:** 2025-1108-0003

**Inspection Type:**

Critical Incident

**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): June 18, 19, 23 and 24, 2025.

The following intake(s) were inspected:

- Intake: #00145845 related to falls prevention,
- Intake: #00149652 related to infection prevention and control.

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

Infection Prevention and Control  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Infection Prevention And Control Program

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

**Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)**

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, two residents' symptoms indicating the presence of infection were monitored in accordance with any standard or protocol issued by the Director.

**Sources:** Two residents' clinical records and interview with the IPAC Lead.

## **WRITTEN NOTIFICATION: Reports re Critical Incidents**

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

**Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.**

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that when an incident that caused an injury, to a resident, that resulted in a significant change in the resident's health condition and taken to a hospital, it was reported to the Director no later than one business day. The DOC stated that the critical incident report was submitted after 2 business days.

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**Sources:** A resident's clinical records, Critical Incident report and an interview to the DOC.