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: September 11, 2025
Inspection Number: 2025-1108-0004
Inspection Type: Complaint 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): September 2 - 4, 9 - 11, 2025

The following intake(s) were inspected:

- Intake: #00149957 and 00155347 - Falls Prevention and Management

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

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

Non-compliance with: O. Reg. 79/10, s. 49 (2)
Falls prevention and management
s. 49 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

The licensee failed to ensure the appropriate monitoring of a resident was completed post fall.

The licensee was required to complete four half hourly checks post fall but documented only one.

Source: Clinical records and interview with staff.

WRITTEN NOTIFICATION: Report Re: Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (1) 2.

A resident had a fall and within a few hours they passed away suddenly. The licensee failed to report the sudden death to the Director.

Source: Clinical records and interview with staff.