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: November 3, 2025
Inspection Number: 2025-1108-0005
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): October 20-24, 27-31 and November 3, 2025.

The following intake(s) were inspected:
-Intakes: #00157993, #00158093 and #00160926, related to prevention of abuse and neglect,
-Intake: #00158206, related to infection prevention and control,
-Intake: #00159639 and #00159841, related to falls prevention.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 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.

The licensee failed to immediately report suspicion of improper care of a resident to the Director when the Director of Care (DOC) was made aware of a resident's injuries.

Sources: a resident's clinical records, a Critical Incident Report and, interview with the DOC.

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) 2.
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:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report suspected and witnessed abuse of a resident by a co-resident, that resulted in harm and a risk of harm on five different days.

Sources: two residents' clinical records, interviews with the Director of Care, the Business Office Manager and an RPN.

WRITTEN NOTIFICATION: Skin And Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that the skin and wound care program was implemented for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the written polices developed for skin and wound assessments was complied with. Specifically, the home's Skin and Wound – Skin Assessment – Head to Toe Policy (last reviewed June 13, 2025) required a head-to-toe skin assessment for all

residents including those at risk of altered skin integrity following an incident that may have caused injury to the skin.

A resident was not provided with the required skin assessment after a physical altercation that resulted in injuries.

Sources: a resident's clinical records, a Critical Incident Report and interview with the DOC.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 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 failed to ensure that when a resident was taken to a hospital and the home was made aware the resident had a significant change in their health conditions that it was reported to the Director no later than one business day. The home reported the incident to the Director two days later.

Sources: a resident's clinical records, a Critical Incident report and, interview with the Administrator.

COMPLIANCE ORDER CO #001 Duty to Protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Re-educate all managers on the Home's policy related to Zero Tolerance of Abuse and Neglect, including when to report to the Director.

b) Provide education to all staff on what constitutes abuse, including on the signs and symptoms to look for when determining suspected or actual abuse that may harm a resident or put a resident at risk of harm.

c) Re-educate all staff that provide one-to one monitoring for a resident on Gentle Persuasive Approaches (GPA).

d) A record of the trainings in a), b) and c), must be kept in the home and include the date and time training was provided, attendees and outline of the course content.

Grounds

A) The licensee failed to protect a resident from abuse by a co-resident.

A resident's responsive behaviours were escalating and attempted to hit a staff. The staff left at the end of their shift leaving the resident unattended. Moments later, the resident exhibited their physical responsive behaviours towards a co-resident causing injury.

Sources: two residents' clinical records, a Critical Incident Report and interview with the DOC.

B) The licensee failed to protect a resident from abuse by staff.

A staff to resident altercation occurred during care and injuries were found and assessed four days later.

The DOC stated that the injuries on the resident's determined that improper care occurred.

Sources: a resident's clinical records and interview with the DOC.

C) The licensee failed to protect a resident from abuse when they were pushed by a co-resident and sustained an injury.

A one-to-one staff was implemented for a resident to ensure their safety and the safety of others. However, the resident was permitted to be alone with another resident in a room which resulted in an incident with injury. The DOC stated that the injury to the resident may have been prevented if the one-to-one staff had been present with the residents.

Sources: two residents' clinical records and interview with the DOC.

This order must be complied with by December 12, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.