

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: October 6, 2025

Inspection Number: 2025-1214-0006

Inspection Type:
Complaint

Licensee: Caessant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caessant Care Marmora, Marmora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25, 26, 2025 and October 2, 3, 2025

The following intake(s) were inspected:

- Intake: #00157511 - Complaint with concerns related to resident care.
- Intake: #00157509 - Complaint with concerns related to resident nutrition.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

WRITTEN NOTIFICATION: Complaints procedure - licensee

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

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure that they immediately forward to the Director the written complaint received related to the care of a resident.

An email was sent to the licensee referencing concerns related to the care of a resident. The licensee submitted a critical incident (CI) complaint/response related to this complaint 17 days later.

Sources: CI #2718-000011-25; resident's health care record; interview with the Executive Director.