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

London District
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Public Report

Report Issue Date: January 10, 2025

Inspection Number: 2024-1226-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care on Bonnie Place, St Thomas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7, 8, 9, 10, 2025

The following intake(s) were inspected:

- Intake #00132347/ Critical Incident System (CIS) #2730-000053-24 related to allegation of neglect of a resident
- Intake #00134487/ CIS #2730-000060-24 related to COVID Outbreak
- Intake #00134827/ CIS #2730-000061-24 related to RSV Outbreak
- Intake #00135879 complaint related to Infection Prevention and Control

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that a resident's written plan of care was clear on how to respond to the resident's care needs.

Sources: CIS #2730-000053-24, home's investigative notes, and staff interviews.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

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

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 (b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

The licensee failed to ensure that all symptomatic residents were monitored every shift during an outbreak.

Sources: Resident clinical records, outbreak list, and staff interviews.