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 East District
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Public Report

Report Issue Date: October 9, 2025
Inspection Number: 2025-1400-0005
Inspection Type:
Complaint
Critical Incident

Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care on McLaughlin Road, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 29, 2025 and October 1 -3, 6 -9, 2025

The following intake(s) were inspected:
- a complaint allegation of neglect of resident and whistle blowing
- a fall intake
- three intakes of allegations of improper/incompetent treatment
- two intakes of allegations of abuse
- a complaint regarding skin and wound care for resident
- three intakes of resident to resident abuse

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

The licensee failed to protect a resident's right to freedom from abuse when there was an altercation with another resident.

Sources: resident's clinical health records, the home's policy, and interviews with resident and staff**.**

WRITTEN NOTIFICATION: Plan of care

NC #002 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; and

The licensee failed to ensure the plan of care for a resident provided clear directions for staff related treatments and clothing.

Sources: resident's clinical health records, home's investigation notes, interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure safe transfer techniques when assisting a resident who had a physical impairment, which resulted in injury.

Sources: home's investigation notes, the home's policy, resident's clinical health records and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure fall prevention interventions and monitoring were provided for a resident, who was identified as high risk for falls, when the resident's fall prevention intervention was not in place at the time of their fall with injury.

Sources: resident's clinical health records, home's investigation notes, interviews with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee failed to ensure a resident received the assistance and supervision from staff that was required to manage and maintain their continence, when the resident fell and sustained an injury.

Sources: resident's clinical health records, interviews with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

(b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident and co-residents, when there were no new strategies or interventions implemented after past incidents and altercations.

Sources: resident's clinical health records, the home's investigation notes, the home's policy, and interviews with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee failed to ensure that steps of identifying and implementing interventions were taken to minimize the risk of altercations and potentially harmful interactions between two residents.

Sources: resident's clinical health records, the home's policy, and interviews with staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (2)

Notification re incidents

s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that residents' substitute decision-makers (SDM) were notified of the results of the investigation immediately upon the completion of the investigation.

Sources: resident's clinical health records, the home's investigation notes, and interview with staff.