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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: December 4, 2025
Inspection Number: 2025-1400-0006
Inspection Type:
Critical Incident
Follow up

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): November 17 - 19, 21, 24 - 28, 2025 and December 1 - 4, 2025
The inspection occurred offsite on the following date(s): December 1, 2025

The following intake(s) were inspected:

- A follow up intake regarding Compliance Order #001/ 2025-1400-0004, O. Reg. 246/22, s. 59 (b), Altercations and other interaction between residents, Compliance Due Date: November 17, 2025.
- An intake regarding alleged sexual abuse of a resident.
- An intake regarding a missing resident.
- An intake regarding a fall of a resident resulting in injury.
- An intake regarding improper care of a resident.
- An intake regarding neglect of residents.
- An intake regarding alleged physical/verbal abuse altercation between co - residents.
- An intake regarding a fall of a resident resulting in injury.
- An intake regarding improper care of resident.
- An intake regarding improper care of resident, resulting in a fall from a mechanical lift.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1400-0004 related to O. Reg. 246/22, s. 59 (b)

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

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
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) 5.
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:
5. Every resident has the right to freedom from neglect by the licensee and staff.

On two separate occasions, a resident was not assisted with care. The Director of Care (DOC) indicated that the resident was neglected when care was not provided when requested.

Sources: Critical Incident Report (CIR), a resident's clinical health records, and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different

aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

1. The Physician was not contacted until five days after receiving positive lab results causing delay in prescribing a treatment. There was a delay in collaboration with the physician, to treat the resident.

Sources: CIR, a resident's clinical records, and interview with staff.

2. A Personal Support Worker (PSW) did not collaborate, in the implementation of a resident's plan of care, when the PSW did not communicate to other staff, that a resident had requested care to be provided.

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

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

Three Personal Support Workers inaccurately documented the outcome of care provided to residents. Specifically, the documentation indicated the resident received a bath, when the resident did not.

Sources: CIR, internal investigation records, and interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

After a fall, a resident's care needs changed due to a new fall risk status and pain. The Director of Care (DOC) confirmed that the care plan should have been updated right away, however fall prevention and pain interventions were delayed 9 and 11 days respectively, from the time it was first reported.

Sources: a resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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.

1. A Personal Support Worker (PSW) did not immediately inform the Director when a resident voiced concerns of being abused by staff members.

Sources: CIR, internal investigation notes, Zero Tolerance of Abuse and Neglect Policy and Procedure.

2. The Food and Nutrition Manager (FNM) and Executive Director (ED) did not immediately report the suspicion of neglect to the Director, when they became aware of four residents not receiving an assigned bath. Two Personal Support Workers (PSWs) voiced concerns to the FNM, that four residents did not appear to have received a bath, even though the documentation indicated it had occurred on the previous shift. The FNM and ED began their investigation by reviewing documentation and video surveillance. There was no indication that baths were provided to three of the residents. The Director was notified of the alleged neglect the following day at 1610 hours.

Sources: CIR, internal investigation notes, and interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning

techniques

NC #006 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.

A Personal Support Worker (PSW) and a PSW student failed to ensure safe transferring techniques when assisting a resident while using a mechanical lift. The resident was transferred while agitated and fell out of the sling onto the floor.

Sources: CIR, internal investigation, a resident's clinical record and interview with staff.

WRITTEN NOTIFICATION: Required Programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The home's policy was not followed by staff, after a resident reported a fall. Comparison of post fall clinical records and assessments, revealed inaccurate and incomplete documentation, contributing to several days of unmanaged pain. A Registered Nurse (RN) and the Director of Care (DOC) confirmed that re-education had been done, when gaps were identified in the completion of the 72 Hour Pain Assessment tools. The DOC confirmed that the resident's unmanaged pain on a specified day, met the criteria for physician notification, and this was not done.

Sources: a resident's clinical records, LTCH's policy 'Pain Management Program Procedure', and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

A resident sustained a fall. The Director of Care (DOC) indicated that the Registered Nurse (RN) did not assess the resident and falsified the documentation of post fall assessment.

Sources: CIR, investigation notes, a resident's post-fall assessments, and an interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

A resident was not assisted to the bathroom, as requested, on two separate occasions. The Director of Care (DOC) indicated that the resident's soiled incontinence products should have been changed, as per the resident's plan of care.

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

WRITTEN NOTIFICATION: Responsive behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment,

reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

A resident was not screened on admission, using the 'Wandering & Elopement Risk Assessment', as per the Licensees policy. The resident eloped from the home, on a specified day. In accordance with O. Reg 246/22, s 11 (1) (b), the licensee was required to ensure that there was written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, was complied with.

Sources: CIR, a resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented.

1. A resident accused staff of assault during personal care and eloped from the building on the same day. As per the internal investigation, delirium was suspected and a lab specimen was obtained. The Licensee’s policy directed the registered nurse to complete a 'Confusion Assessment Method' (CAM), to screen for delirium, and it was not completed.

Sources: CIR, a resident's clinical records and interview with staff.

2. A resident was assigned 30 minute assessments, using a BSO-DOS assessment tool for documentation. The assessment tool did not accurately reflect the residents status at the time of the elopement.

Sources: CIR, a resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with Additional Requirement 10.2 (a) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), an opportunity to complete hand hygiene was not promoted to residents, after a group activity involving shared equipment. The home had been declared in a facility wide outbreak.

Sources: observations, and interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

1. The 'Infection Screening Evaluation' was not completed when a resident was exhibiting signs and symptoms of a suspected infection.

Sources: CIR, a resident's clinical records, and 'IPAC Daily Surveillance P and P'.

2. On the day after the home was declared in a facility wide outbreak, the Inspector found no outbreak notification signage at the entrance of the home, to inform individuals.

Sources: observation, home's 'Outbreak Management Policy'.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (d)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

The former Director of Care (DOC) did not ensure all individuals were interviewed during an alleged sexual abuse investigation, including co-workers and other witnesses.

Sources: CIR, 'Zero Tolerance of Abuse and Neglect Policy', and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

A resident returned from the hospital due to concerns of new pain, and informed staff that they had fallen the day before. The resident continued to report severe pain in the days after the fall, requiring new and increased medication for treatment. The home did not submit a CIR until 10 days after becoming aware of the fall.

Sources: CIR, and interview with staff.

COMPLIANCE ORDER CO #001 Required programs

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Facilitate structured discussions (e.g., nursing huddles or team meetings), lead by the Director of Care (DOC) or designate, to explore how registered staff can maintain compliance with the Fall Prevention and Management Program.

- Encourage open dialogue to uncover systemic or workflow issues.
- Document all feedback, including dates, discussion points, and names of participants.

2. Develop and Implement a Plan.

Based on the information gathered from the Registered Nursing staff, the licensee shall develop, implement, and document a plan to ensure registered nursing staff maintain compliance in the Fall Prevention and Management Program.

Grounds

Ontario regulation 246/22, section 11 (1) (b), required the licensee of a long-term care home to have, institute or otherwise put in place a fall prevention and management program and to ensure that the program was complied with.

1. A resident sustained a fall and was lifted off the floor without the use of a mechanical lift as directed by the home's policy.

Not following the home's 'Fall Management Program – Post-Fall Management Procedure' by using a mechanical lift with a sling to assist the resident off the floor, placed the resident at risk of additional harm.

Sources: CIR, investigation notes, the home’s policy “Fall Management Program – Post-Fall Management Procedure”, and an interview with staff.

2. A resident reported a fall on the previous day. The head injury routine, falls risk assessment, and care plan fall interventions were either delayed or incomplete. Additionally, the 72-hour shift-to-shift fall incident progress notes and electronic treatment administration record (eTAR) checks, were not completed as per policy.

A resident was placed at an increased risk of falls when registered nursing staff missed or delayed initiation of assessments, reassessments and fall interventions, as per the home's policy.

Sources: The homes 'Fall Management Program - Post Fall Management Procedure', a resident's clinical records, and interview with staff.

This order must be complied with by: February 27, 2026

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.