

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: March 11, 2026

Inspection Number: 2026-1400-0001

Inspection Type:

Complaint
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): March 2 to 6, 9 to 11, 2026.

The following intake(s) were inspected:

- Follow-up intake related to a required programs compliance order.
- Complaint intake related to alleged neglect/abuse of a resident.
- Critical Incident (CI) intake related to alleged staff to resident abuse.
- CI intake related to misuse or misappropriation of a resident's money.
- Two CI intakes related to alleged resident to resident physical abuse.
- CI intake related to loss of an essential service.
- CI intake related to missing/unaccounted controlled substance.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1400-0006 related to O. Reg. 246/22, s. 53 (1) 1.

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

Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RIGHT TO QUALITY CARE AND SELF-DETERMINATION

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 17.

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:

17. Every resident has the right to be told both who is responsible for and who is providing the resident's direct care.

A resident who preferred female caregivers for personal care, was provided baths, dressing and hygiene care by a male staff, over a three month time period.

Source: resident clinical records and staff interview.

WRITTEN NOTIFICATION: Foot care and nail care

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

Non-compliance with: O. Reg. 246/22, s. 39 (1)

Foot care and nail care

s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

On a specified date, a resident exhibited dry, thickened skin on both feet, and untrimmed, thick toe nails. The licensee did not provide basic foot care, such as toenail cutting, to promote comfort and minimize the risk of infection.

Source: resident clinical records, staff interview.

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WRITTEN NOTIFICATION: Foot care and nail care

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

Non-compliance with: O. Reg. 246/22, s. 39 (2)

Foot care and nail care

s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

On a specified date, a resident was observed to have overgrown, unkept fingernails with debris present. The licensee did not provide the necessary fingernail care, including nail trimming, as required.

Source: resident observation and clinical records.

WRITTEN NOTIFICATION: Behaviours and altercations

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

Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

A resident's care plan was not revised after two separate resident to resident altercations. Specifically, procedures and interventions to minimize the risk of altercation and potential harmful interactions with residents in a specific location.

Source: Critical Incident Reports, resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Police notification

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

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

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s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

An allegation of physical abuse incident that occurred on a specified date, involving a resident, was not reported to the police, despite visible skin alteration of unknown cause.

Source: Critical Incident Report, Long-Term Care Home's policy for Abuse and Neglect, resident clinical records, interview with staff.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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