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**
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

# Public Report

**Report Issue Date:** January 30, 2025

**Inspection Number:** 2025-1144-0001

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Caressant-Care Nursing and Retirement Homes Limited

**Long Term Care Home and City:** Caressant Care Woodstock Nursing Home, Woodstock

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 27, 28, 30, 2025

The following intake(s) were inspected:

- Intake: #00134727 - Critical Incident System (CIS) report #2636-000067-24, related to allegations of improper care of a resident;
- Intake: #00135781 - Complaint related to Food Production; and
- Intake: #00137791 - CIS #2636-000007-25, related to a resident fall.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Falls Prevention and Management

# 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 (2)**
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care for a resident was based on the resident's assessed care needs.

Sources: Clinical records, and an interview with the ADOC.

## WRITTEN NOTIFICATION: Residents' drug regimes

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 146 (b)**
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(b) appropriate actions are taken in response to any medication incident involving a resident, any incidents of severe hypoglycemia and unresponsive hypoglycemia and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs.

The licensee failed to ensure all appropriate actions were taken in response to a resident's medical condition when, the interdisciplinary team was not notified consistently, including the pharmacy service provider, and the incidents were not analyzed quarterly.

Sources: Clinical records and interviews with the Administrator, the Director of Care and the Assistant Director of Care.