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: August 29, 2025

Inspection Number: 2025-1144-0006

Inspection Type:
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):
August 20, 21, 22, 25, 26, 27, and 28, 2025

The following Critical Incident intake(s) were inspected:

- Intake: #00151649 [2636-000057-25] related to Fall Prevention & Management
- Intake: #00152249 [2636-000058-25] related to Fall Prevention & Management
- Intake: #00154528 [2636-000065-25] related to Prevention of Abuse & Neglect

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

Prevention of Abuse and Neglect
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 (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 that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care.

The care plan documented an intervention to be implemented within parameters ordered by a physician". The physician's order and the resident's progress notes identified directions that did not match the plan of care and the implementation of the therapy. The Director of Care (DOC) stated there was an order written by the Nurse Practitioner and verified there was no documented record of an assessment and the care plan did not provide clear direction to the registered or Personal Support Workers (PSW) responsible for the therapy.

Sources: resident's clinical record review of physician orders, care plan, progress notes, and assessments, observations of the resident and staff interviews with PSWs and the DOC.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home submitted a Critical incident report to the Ministry of Long-Term Care documented allegations of suspected staff to resident abuse. The PSWs did not report the allegations immediately to the registered nursing staff at the time of the incidents.

The Caressant Care Zero Tolerance of Abuse and Neglect Policy and Procedure documented all staff must immediately report to the Registered Staff suspected or witnessed incidents of abuse or neglect.

During interviews with the residents there was no reported concerns related to their care and there were no assessed injuries or negative outcomes identified during the home's investigation.

Sources: review of the home's investigation notes and Zero Tolerance of Abuse and Neglect Policy, resident clinical record reviews, observations and interviews of residents, and staff interviews with PSWs, Director of Care, and Executive Director.