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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: June 3, 2025
Inspection Number: 2025-1396-0002
Inspection Type: Complaint
Licensee: Delcare LTC Inc.
Long Term Care Home and City: Cawthra Gardens, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 20, 22-23, 27-30 and June 3, 2025

The following intake(s) were inspected:

- Intake: #00143340 - Complaint with concerns related to prevention of abuse and neglect, reporting and complaints, continence care, and whistle blowing protection and retaliation.
- Intake: #00144525 - Complaint with concerns related to resident care and support services, plan of care, prevention of abuse and neglect, and responsive behaviours.

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

Continence Care
Resident Care and Support Services
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care, which indicated how the resident would receive total assistance with personal hygiene, was provided to them as specified in the plan.

On a specified date in December 2024, two staff did not reference or follow the resident's plan of care resulting in direct personal care provided to the resident not as indicated in the plan.

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

WRITTEN NOTIFICATION: Pain management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee has failed to comply with the home's pain management policy when a resident, who is unable to communicate their pain and is cognitively impaired, was not assessed for pain when they demonstrated increased responsive behaviours on a specified date in March 2025.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for pain management were complied with.

Specifically, the resident was presenting with behavioural indicators for pain, with no effect when interventions to address these behaviours were provided by staff. The resident was unable to verbally express their pain and a pain assessment was not completed to further investigate the increased agitation.

Sources: the resident's clinical records; Pain Management policy; and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were implemented to respond to a resident's responsive behaviours.

Specifically, the resident had a history of physically responsive behaviours towards

co-residents and an intervention to address this was indicated in their care plan. This was not implemented on a specified date in January 2025, when the resident acted on the responsive behaviour towards a co-resident.

Sources: The resident's clinical records and an interview with staff.

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137