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: May 20, 2025

Inspection Number: 2025-1200-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Lindsay Nursing Home, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7 - 9, 12 - 14, 2025
The inspection occurred offsite on the following date(s): May 14, 2025

The following intake(s) were inspected:

- Intake: #00135299 - eCorrespondence-Central East District-Case #245-2024-2943- Complaint - Emotional abuse of resident
- Intake: #00135315 - Emotional abuse of resident by staff
- Intake: #00136077 - Fall of resident - sustained fracture
- Intake: #00136106 - Emotional abuse of resident by staff
- Intake: #00139079 - Complaint - Concern re: temperature and variety of food.
- Intake: #00142572 - Resident to resident physical abuse

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
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:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident's privacy was protected when a staff member questioned a choice the resident had made in a public place. The staff member was not part of the resident's circle of care and should not have had access to the resident's care and treatment information.

Sources: CIR #2701-000048-24, letter of complaint, resident's clinical records, interviews with the ED, DOC and BSO RN [741754]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 provide direct care to the resident. Updates to the written care plan were not made between two incidents with injuries on specific dates. The Falls Lead confirmed that the resident's current care plan required updating, as they were no longer totally dependent, requiring full staff performance of activity every day. An intervention was initiated on a specific date which was not included in the written plan of care.

Sources: CIR #2701-000001-25, resident's clinical records, Falls Committee minutes, Falls Lead interview. [741721]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
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,
(c) care set out in the plan has not been effective.

The licensee failed to reassess, review and revise the care plan when the care set out in the plan had not been effective for a resident. The resident's care plan directed staff to have an intervention in place and functioning so that staff could be alerted and respond promptly. The resident sustained an injury on a specific date, when they were found on the floor, and the intervention was not functioning. Despite knowing that the resident was able to disable the intervention, the home continued to use it to alert them when the resident was attempting to self ambulate.

Sources: CIR #2701-000001-25, resident's clinical records, 01/01/2025 Post Fall Investigation Assessment, Fall Committee meeting minutes, staff interviews (PSW and Director of Care). [741721]

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from emotional abuse by a staff member when they were questioned in public about a treatment decision and subsequently felt upset and distraught.

Sources: CIR #2701-000048-24, letter of complaint, home's internal investigation file, interviews with ED and DOC [741754]

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