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: June 27, 2025

Inspection Number: 2025-1200-0004

Inspection Type:
Complaint
Critical Incident
Follow up

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): June 16-20, and 23-26, 2025.

The following intake(s) were inspected:

- Intake related to Follow-up #: 1 - CO #001 / 2025-1200-0001, O. Reg. 246/22 - s. 79 (1) 5. Dining and Snack Service.
- Intake related to a complainant regarding an injury of a resident.
- Intake related to a complaint regarding the abuse of a resident.
- Intake related to resident to resident abuse.
- Intake related to resident to resident abuse.
- Intake related to the fall of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1200-0001 related to O. Reg. 246/22, s. 79 (1) 5.

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

Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's substitute decision maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

An intervention was implemented for a resident and the licensee advised them that there were limitations with the intervention during direct resident care.

The Executive Director (ED) acknowledged that the SDM has expressed concerns about the intervention as well as concerns for the resident's safety.

Sources: Complaint, policies, interviews with Assistant Director of Care (ADOC), Behaviour Support Ontario (BSO) Lead, Director of Care (DOC) and ED.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that a resident's call bell was accessible.

During an observation, the home's communication and response system was triggered alerting staff of an emergency in a resident's washroom. The resident could be heard attempting to get the attention of staff. A Registered Nurse (RN) confirmed that the resident did not have access to a chord to pull the call bell when the resident is in their bed. The DOC confirmed that the resident utilized another method to alert staff that was not the use of the call bell.

Sources: Policy, observations, a resident's clinical health records, and interviews with the resident and RN.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee failed to ensure that a resident was provided assistance from staff during toileting.

An observation was conducted related to the home's communication and response system, as alert indicated an emergency in a resident's washroom. The alert identified the call was unanswered for a number of minutes and the resident could be heard requesting the attention of staff.

On review of the resident's care plan, there is indication the resident requires assistance of staff member for toileting. During an interview, the resident indicated that they wait a signification amount of time before staff address their needs.

Sources: Policy, observations, a resident's clinical health records, and interviews with the resident and a RN.

WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain

management strategies.

The licensee failed to ensure that a resident's pain was monitored.

A Critical Incident Report (CIR) was submitted related to the fall of a resident. The resident's clinical health records indicated the resident had a new onset of pain. Documentation completed by registered staff, confirms the resident's pain was not monitored after the initial onset. During an interview with the DOC, they confirmed that the resident's pain was to be monitored on the initial onset of pain.

Sources: Policy, a resident's clinical health records, and interview with the DOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee failed to ensure that foods and fluids were served at a temperature that was safe and palatable to the resident.

During an interview with a resident, they indicated that on a specified date, during a meal service, they were served soup that was cold. A Dietary Aide confirmed that they did not take the temperatures of the soup served. The Food and Nutrition Manger (FNM) confirmed there were no records that indicated temperatures were taken of the soup served.

Sources: Temperature records, policy, interviews with a resident, a Dietary Aide and the FNM.

WRITTEN NOTIFICATION: Police notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
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).

The licensee failed to ensure the appropriate police force was notified immediately of an alleged incident. Specifically, when the licensee waited until the following day to substantiate the allegations.

Sources: Home's investigation notes, a resident's clinical health records, interviews with the ADOC, DOC and ED.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee failed to report an incident that caused an injury that resulted in a significant change in a resident's condition.

A resident experienced an incident that caused injury for which the resident was taken to hospital which resulted in a significant change in condition on a specified date. The Director was notified a number of days later. The DOC acknowledged that the incident involving the resident should have been reported sooner.

Sources: CIR, a resident's clinical health records, internal investigation notes and interview with the DOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (6)
Reports re critical incidents
s. 115 (6) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 246/22, s. 115 (6).

The licensee failed to inform a resident's SDM of an incident that resulted in an

injury.

A review of clinical health records for a resident indicated they sustained a fall on a specified date. During an interview with a Registered Practical Nurse (RPN) they indicated that the resident's SDM had provided another individual to contact in the event of an emergency. The DOC confirmed that the resident's SDM or the emergency contact had not been informed of the fall.

Sources: CIR, a resident's clinical health records, internal investigation notes and interviews with a RPN and the DOC.

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee is ordered to:
1. Provide training to the Assistant Director of Care (ADOC), and Executive Director (ED) on the zero tolerance of abuse policy and managing responsive behaviours. This training is to be in addition to the home's regular education platform.
2. Keep a record of the training, including training content, trainer name, date of training, staff attendance and signatures, and provide to the Inspector upon request.
3. Communicate to all direct staff, by a method of the home's choice, the definition of abuse, and types of behaviours, that pose a risk of harm to residents and how to manage responsive behaviours.
4. Keep a record of the communication to direct staff, the date(s) it was

communicated and the staff names it was communicated to, and provide to the Inspector upon request.

Grounds

The licensee failed to protect a resident from abuse by another resident.

Clinical health records for a resident indicated they had responsive behaviours. The plan of care for the resident was updated with interventions to prevent expressions of responsive behaviours.

On a specified date, the SDM of a resident reported to the home they observed another resident in the room of the co-resident. The ADOC reported the concern to the ED who acknowledged they wanted to wait to substantiate the allegations of abuse.

The DOC, ADOC and ED substantiated the allegations as abuse and initiated an intervention for the resident involved.

Clinical health records for both residents on a specified date, document multiple times that the resident was found in the other resident's room by staff. The home received confirmation that a second incident of abuse occurred on a specified date, prior to the home initiating an intervention.

Failure to protect the resident from abuse resulted in further incidents of abuse of the resident.

Sources: Investigation notes for CIRs, residents clinical health records, policy, interviews with a RPN, ED, DOC and ADOC.

This order must be complied with by September 15, 2025

COMPLIANCE ORDER CO #002 Licensee must investigate, respond and act

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee is ordered to:
1. Provide training to the Assistant Director of Care (ADOC) and Executive Director (ED) on the actions to be taken following a report of alleged, suspected or witnessed abuse.
2. Keep a record of the training: including a copy of the training content, the trainer's name, date of the training, staff name and signature.
3. Provide a copy to the Inspector upon request.
4. Communicate to direct care staff, by a method of the home's choice the actions to be taken by all staff following a report of alleged, suspected or witnessed abuse.
5. Keep a copy of the communication, including the date it was communicated and a list of staff it was communicated to.

Grounds

The licensee has failed to ensure that appropriate action in response to allegations of abuse of a resident by another resident.

The home's zero tolerance abuse and neglect policy indicates for any alleged

abuse, an investigation will commence immediately and the Registered staff will ensure the resident is assessed, assisted and supported and provided interventions to ensure the safety and comfort of the resident, as well as any preventative measures to be applied for safety and prevention of any further occurrences.

The ADOC and ED acknowledged they did not take the actions of their abuse and neglect policy when they received allegations of abuse towards a resident by another resident on specified date.

Failing to ensure that appropriate action was taken in response to allegations of abuse did not ensure the safety of the resident or prevent further occurrences of abuse by the co-resident.

Sources: CIRs, zero tolerance of abuse and neglect procedure, interviews with ED, DOC and ADOC.

This order must be complied with by September 15, 2025

COMPLIANCE ORDER CO #003 Reporting certain matters to Director

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee is ordered to:

1. Provide training to the Assistant Director of Care (ADOC), and Executive Director (ED) on the reporting requirements under section 28 of the Fixing Long Term Care Act 2021. This training is to be in addition to the home's regular education platform.
2. Keep a record of the training, including training content, trainer name, date of training, staff attendance and signatures, and provide to the Inspector upon request.
3. Communicate to all direct staff, by a method of the home's choice, the duty of the licensee and all staff to report alleged, suspected or witnessed abuse to the Director directly when there is a risk of harm, or harm, to a resident, the definition and types of behaviours, that pose a risk of harm to residents and how to manage responsive behaviours.
4. Keep a record of the communication to direct staff, the date(s) it was communicated and the staff names it was communicated to, and provide to the Inspector upon request.

Grounds

The licensee failed to report abuse allegations of a resident by another resident.

A family member reported to the ADOC an allegation of resident to resident abuse.

The ADOC and ED indicated that the home's policy is to report abuse allegations immediately and acknowledged they did not report the allegations immediately as they wanted to wait to substantiate the allegations.

The ED acknowledged the home substantiated the allegations on a specified date. The ED confirmed a second incident of abuse occurred on a specified date, prior to the home initiating safety interventions.

Failure to report the abuse allegations immediately resulted in a delay in implementing safety supervision of the resident and a second abuse incident occurring.

Sources: Investigation notes for CIR, residents clinical health records, homes policy for abuse and neglect, interviews with ED, DOC and ADOC.

This order must be complied with by September 15, 2025

COMPLIANCE ORDER CO #004 Behaviours and altercations

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee is ordered to:
1. Identify and implement interventions for a resident to minimize behaviours and risk of potentially harmful interactions towards other residents, including identifying triggers, responsive behaviours, and responding to altercations and potentially harmful resident to resident interactions.
2. Update the plan of care for the resident to include the interventions identified.
3. Keep a written copy of the updated plan of care for the resident and an attendance record of the interdisciplinary team who participated in the reviewing

and updating the plan of care. Provide to the Inspector upon request.
4. The Director of Care or designate shall provide education to all direct care staff, including agency, of a specified home area, of the plan of care and interventions for the resident to minimize altercations and risk of potentially harmful interactions towards other residents.
5. Keep a written copy of attendance for education including who provided the education, the date the education was provided, name and signature of staff and the content of education provided.

Grounds

The licensee has failed to ensure that procedures and interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between a resident and their co-residents.

The plan of care for a resident indicated they had responsive behaviours, A BSO behaviour assessment was completed on a specified date for the resident. The home did not initiate a BSO referral or update the resident's plan of care with any new interventions to minimize the risk of potentially harmful interactions with other residents.

Interview with the BSO lead indicated the home has a policy for the identification and management of responsive behaviours.

The ADOC indicated they received a call from the family of a resident who reported an allegation of abuse of a resident. The ED acknowledged the home waited until the following day to substantiate the allegations as abuse and implement procedures and interventions to minimize the risk of further altercations and harmful interactions by the resident with other residents. The ED also acknowledged there was a second incident of abuse on a specified date. Prior to the home reviewing the first incident of abuse and initiating an intervention for safety.

Failure to ensure that there were procedures and interventions in place to minimize the risk of altercations and potentially harmful interactions resulted in abuse of the resident.

Sources: CIRs, clinical health records of residents, policies interviews with Personal Support Workers (PSW), RPN, BSO Lead, ADOC, DOC and ED.

This order must be complied with by September 15, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.