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
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: January 30, 2025

Inspection Number: 2025-1400-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care on McLaughlin Road, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20 - 24 and 27, 28, and 30, 2025.
The inspection occurred offsite on the following date(s): January 29, 2025.

The following intake(s) were inspected:

- Four intakes related to allegations of staff to resident neglect.
- An intake related to the fall of a resident.
- An intake related to an allegation of improper care of a resident.
- Three intakes related to a complaint regarding medication administration, skin and wound care, communication.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Consent

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 7
Consent
s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent.

The licensee failed to obtain consent when care or services were provided for a resident.

A complaint was received by the Ministry of Long-Term Care alleging consent was not obtained for a new prescribed medication for a resident.

From the time of admission to the LTC home, the resident had appointed substitute decision makers (SDMs). The resident was prescribed a new medication, to be administered daily. Two days later, after two doses of the new medication had been administered to the resident, the resident's SDM was contacted to obtain consent.

Sources: Resident's clinical records, interview with staff, medication incident report.

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 compliance with their written policy to promote zero tolerance of abuse and neglect of residents.

Section 7 of the Ontario Regulation 246/22 defines ""neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical incident report was submitted to the Director, alleging neglect of a resident by staff, noting that three personal support workers (PSWs) were aware that the resident required care and delayed in providing care for the resident. Two PSWs later provided the care for the resident. The Resident Care Coordinator (RCC) confirmed that following the home's internal investigation, the allegation was substantiated.

Sources: Interview with staff, LTC home's internal investigation documents, resident's clinical records, LTC home's policy.

WRITTEN NOTIFICATION: Medication management system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-

based practices and, if there are none, in accordance with prevailing practices; and

The Licensee failed to implement their medication management policy, specifically processing the Prescriber's Order and Discontinued Medication orders.

The internal investigation note indicated an order for a resident that was not processed. The digital prescriber's order note showed that the order was discontinued two weeks after the order date. Further, staff indicated the order was not in the system and confirmed that it was not processed, transcribed, and discontinued per the home's medication management procedures and policy.

Sources: LTC Home's internal investigation, LTC home's policy, Digital Prescriber's order form, medication administration record, and interview with staff.