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

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| **Report Issue Date:** March 13, 2025 |
| **Inspection Number:** 2025-1400-0002 |
| **Inspection Type:**<br>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): March 4, 5, 7, and 10 -13, 2025.
The inspection occurred offsite on the following date(s): March 6, 2025.

The following intake(s) were inspected:

- Intakes #00107595 - CI #2916-000006-24, #00116452 - CI #2916-000035-24, #00140600 - CI #2916-000006-25 - related to allegations of improper care of residents.
- Intakes #00107739 - CI #2916-000007-24, #00113022 - CI #2916-000017-24, #00113617 - CI #2916-000021-24, #00115544 - CI #2916-000030-24, #00122266 - 2916-000043-24 - related to allegations of staff to resident neglect.
- Intake #00112243 - CI #2916-000016-24 - related to an allegation of staff to resident abuse.
- Intake #00115751 - CI #2916-000032-24 - related to an incident that caused an injury to a resident.
- Intakes #00125517 - CI #2916-000047-24, #00132717 - CI #2916-000052-24 - related to resident-to-resident altercations.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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) 5.**
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:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee failed to protect two residents from neglect when multiple care needs were not met and the residents were not provided assistance on a specific date.

**Sources:** home's internal investigation file, email complaint, interview with Executive Director (ED).

## WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (4) (b)**
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of

care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff involved in the care of a resident collaborated with each other in implementing the resident's plan of care interventions.

**Sources:** Resident's clinical records, home's investigation notes, interviews with staff.

## WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**
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,
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or

1.The Licensee failed to update a resident's written plan of care with new interventions when the resident's care needs changed.

**Sources:** CI reports, LTC home's internal investigation notes, resident's clinical record, interviews with staff.

2.The licensee failed to ensure that a resident' s plan of care was updated when their needs changed.

The Resident Care Coordinator (RCC) acknowledged that the plan of care for the resident should have been updated to include specific interventions.

**Sources:** Resident's clinical records, LTC Home's Policy, interviews with staff.

3.The licensee failed to ensure that a resident's plan of care was updated when their care needs

changed.

The BS0-PSW indicated the resident had interventions implemented following a resident to resident altercation, and the Resident Care Coordinator acknowledged that they should have been updated in their plan of care.

**Sources:** Clinical records for resident, interviews with staff.

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 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 its written policy promoting zero tolerance for the abuse and neglect of residents.

Section 2. (1) (a) of the Ontario Regulation 246/22 defines “emotional abuse” as, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A critical incident report was submitted to the Director, alleging verbal/emotional abuse of a resident by staff, which diminished the resident's dignity and self-worth. A staff member witnessed the incident and made the complaint to management, and the resident acknowledged the impact of the incident. The ED acknowledged that the incident was a staff-to-resident emotional abuse; the staff member did not follow the home's policy that treats residents with dignity and respect.

**Source:** Interview with the resident, LTC Home's internal investigation record, LTC Home's Policy, interview with ED.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 1.**
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report allegations of improper care of a resident to the Director.

Clinical records included documentation that the resident had altered skin integrity related to the use of a device. The ED indicated it is the expectation of the home that allegations of improper care are reported immediately and acknowledged it was reported to the Director two days later.

**Sources:** Critical Incident Report (CIR), LTC Home's Policy, interview with ED.

## WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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.

1.The licensee failed to ensure that it was immediately reported to the Director when there was an allegation of neglect of a resident by staff.

A staff member confirmed they became aware of the allegation of neglect of the resident, and they submitted the critical incident report more than one day later. The staff member indicated they were aware that an allegation of neglect should be reported immediately.

**Sources:** CI report, interview with staff.

2.The licensee failed to ensure that it was immediately reported to the Director when there was an allegation of neglect of a resident by staff.

Clinical records for the resident indicated the allegations of neglect occurred, and the Critical Incident Report (CIR) was submitted the following day. Three staff members indicated that the home has a Zero Tolerance of Abuse and Neglect Policy and acknowledged the allegations should have been reported immediately.

**Sources:** CI Report, clinical records of resident, LTC Home's Policy, interviews with staff.

3.The licensee failed to ensure that it was immediately reported to the Director when a resident abuse incident was witnessed by staff.

A critical incident system (CIS) report was submitted to the director, indicating that staff witnessed emotionally abusive communication directed towards a resident by a staff member. An interview with the ED confirmed that the staff who witnessed the incident submitted an email complaint more than three weeks after the incident, and the home did not address the late reporting.

**Source:** CIR, interview with the ED.

## WRITTEN NOTIFICATION: Nursing and personal support services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)**
Nursing and personal support services
s. 35 (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

The licensee has failed to ensure that two residents were provided with care according to their assessed needs.

On a specific date, two residents did not receive assistance with their assessed needs.

**Sources:** LTC home's internal investigation notes, staff attendance record for relevant shift, LTC home's policy, interviews with staff.

## WRITTEN NOTIFICATION: Oral care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)**
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received morning oral care to maintain the integrity of their oral tissue.

A Critical Incident Report (CIR) was submitted to the Director indicating that the PSW assigned to provide morning care to the resident did not complete the morning care tasks on a specific date. An interview with staff confirmed that the PSW failed to provide full morning care to the resident, including oral hygiene as outlined in the care plan.

**Source:** Interview with staff, resident's clinical records, CIR.

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 40**
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring techniques when assisting a resident. Specifically, they left the resident unattended while using a device. Two staff members indicated the home has a policy on lift and transfers, and acknowledged that residents are not to be left unattended when using the device.

**Sources:** Resident's clinical records, LTC Home's Policy, interviews with staff.

## WRITTEN NOTIFICATION: Personal items and personal aids

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 41 (2)**
Personal items and personal aids
s. 41 (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids.

The licensee failed to ensure that a resident received assistance in using their personal aid as specified in the care plan.

A Critical Incident Report (CIR) was submitted to the Director indicating that the assigned staff member for the morning care of the resident did not complete the morning care tasks on a specific date. An interview with a staff member confirmed that the assigned PSW failed to assist the resident with using a personal aid.

**Source:** Interview with staff, resident's clinical records, CIR.

## WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee failed to ensure that two residents, who were dependent on staff for repositioning, were repositioned every two hours during a shift on a specific date.

**Sources:** residents' clinical records, CIR, LTC home's internal investigation file, interviews with staff.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #012 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 the assistance they required by staff to manage and maintain continence.

A Critical Incident Report (CIR) was submitted to the Director indicating that the assigned staff member did not complete the morning care tasks for the resident on a specific date. An

interview with a staff member confirmed that the PSW failed to provide full morning care for the resident, including assisting with managing continence.

**Source:** Interview with staff, resident clinical records, CIR.

## WRITTEN NOTIFICATION: Dining and snack service

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)**
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure that a resident was provided assistance with eating and drinking after being served their meal on a specific date, when no one was available to provide the assistance they required.

**Sources:** resident's clinical records, LTC home's internal investigation notes, interview with the ED.

## WRITTEN NOTIFICATION: Police notification

NC #014 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 that the police were notified of allegations of neglect of a resident.

A staff member indicated it is the expectation of the home that allegations of abuse and neglect

are reported to the police service, and acknowledged this was not done.

**Sources:** CIR, LTC home's policy, interview with staff.

## WRITTEN NOTIFICATION: Additional requirement, s. 26 of the Act

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 109 (1)**
Additional requirements, s. 26 of the Act
s. 109 (1) A complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

The licensee failed to immediately forward to the Director a complaint that alleged harm to two residents.

A complaint that alleged harm to two residents was received and was not immediately forwarded to the Director.

**Sources:** LTC home's internal investigation file, CIR, LTC home's policy, interview with staff.

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (2)**
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee failed to report allegations of neglect of a resident to the Ministry's after hours contact.

The LTC home's policy directs that after hours, the registered staff are to immediately report all incidents of suspected or witnessed abuse or neglect of a resident by telephone to the Ministry after hours line. The RCC acknowledged that the staff did not report to the Ministry after hours contact as per policy.

**Sources**: CIR, LTC home's policy, interview with RCC.

## COMPLIANCE ORDER CO #001 Dining and snack service

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.**
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:
3. Monitoring of all residents during meals.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
**Specifically, the licensee shall:**
1. The Registered Dietitian (RD) and a leadership team designate will identify and create a list of all residents of Unit 2 who require modified diet textures and require supervision or assistance with meals as per their plan of care, with a notation on each resident's specific need(s). The list will be maintained and updated as any resident's needs change.
2. The RD and a leadership team designate will deliver in-person training to all Unit 2 staff (including agency staff) on the care plan interventions to be implemented for residents with modified diet textures and who require supervision or assistance during meal time.
3. The list of residents reviewed and identified as requiring additional measures will be retained. Training content and attendance records (containing the trainer’s full name and title, staff’s full name and role, training dates and location) are to be documented and made available to an inspector upon request.
4. The RD or a leadership team designate conduct a minimum of two random audits weekly of dinner meals in Unit 2, including the dining room and tray service, for three weeks following the service of this order to ensure that identified residents from item #1 are being supervised as per their plan of care.

**Grounds**
The licensee failed to ensure that a resident was monitored during a meal.

A critical incident report was submitted to the Director regarding an incident that caused injury to a resident, when the resident was eating a meal.

The written care plan and the Registered Dietitian's assessment notes indicated the resident required specific interventions at meal time.

A co-resident confirmed that they asked for staff assistance when an incident occurred with the resident during the meal. A PSW indicated they responded and found the resident with a change in their health condition. The PSW indicated there should have been supervision for the resident, but there was no staff there and the resident had their meal.

The Registered Dietitian and Executive Director both confirmed that for residents with specific meal time interventions, they cannot be left alone with their food.

There was a high risk and impact on the resident’s safety and well-being when they were not monitored during their meal.

**Sources:** Resident's clinical records, interviews with staff.

**This order must be complied with by** May 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.