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 29, 2025

Inspection Number: 2025-1400-0003

Inspection Type:
Complaint
Critical Incident
Follow up

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): May 20-23, 26- 29, 2025.

The following intake(s) were inspected:
Intakes related to falls.
Intake related to improper care.
Intakes related to abuse.
Intake related to a choking incident.
Intake- First Follow-up- CO #001 (CO(HP)) from inspection 2025-1400-0002, related to O. Reg. 246/22 - s. 79 (1) 3, monitoring of residents during meals, with Compliance Due Date (CDD) of May 15, 2025.
Intake related to a complaint regarding menu planning, portion sizes and staffing.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1400-0002 related to O. Reg. 246/22, s. 79 (1) 3.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
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) 4.
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:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure that the right of resident, to be free from abuse was fully respected and promoted. Specifically, a personal support worker (PSW) made an inappropriate comment to resident while providing care, which made the resident feel insulted and upset.

Source: Investigation notes and interviews with resident and PSW.

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 has failed to ensure that the written plan of care provided clear directions to staff providing direct care to resident with respect to their mobility status.

Specifically, the written plan of care contradicted the physiotherapist's (PT) assessment, related to the resident's mobility status. Registered Practical Nurse (RPN), acknowledged that there was unclear guidance for the staff concerning the resident's mobility.

Sources: observations, resident's written plan of care, interview with PT and RPN.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of a resident, that resulted in harm, or a risk of harm immediately reported the suspicion and the information upon which it was based to the Director. Specifically, a critical incident related to improper or incompetent care, was not reported to the Ministry until the following day.

Source: Critical Incident Report

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident, that resulted in harm, or a risk of harm immediately reported the suspicion and the information upon which it was based to the Director. Specifically, a critical incident related to abuse of a resident, which was not reported to the Ministry until the following day.

Source: Critical Incident Report

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 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 has failed to ensure that staff used safe positioning techniques when assisting a resident with care in bed which resulted in risk of harm.

Source: Investigation notes and interviews with resident and PSW.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (f)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

The licensee has failed to ensure that a range of continence care products were available and accessible to residents and staff at all times, and sufficient quantities for all required changes. Specifically, the Personal Support Worker confirmed that certain sizes of continence care products were unavailable from May 17 – 21, 2025, and staff had to use alternative sizes during that period.

Source: Interview with resident and PSW.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to comply with the nutritional care and hydration program when the home failed to implement interventions to mitigate nutrition risk for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b) the licensee was required to ensure that a home specific policy was complied with. Specifically, the home failed to provide the appropriate food texture to the resident, after an incident which had occurred. This change was not made until the Registered Dietitian (RD) completed an assessment.

Sources: Critical Incident Report, home's internal investigation, Home specific policy, and interview with RD.

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 (3) 4.
Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the fall sustained by a resident, which resulted in injury and hospitalization, was reported to the Director within one business day. The resident was transferred to the hospital and returned the following day with an injury and a decline in condition.

Review of Critical Incident System (CIS) report, indicated the date the incident was first submitted to the Ministry of Long-Term Care (MLTC) was four days after the incident.

Sources: Resident clinical records, CIS report and interview with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Review the plan of care for identified residents with the direct care providers that provide care to these residents to ensure they are aware of the contents of the plan of care. This review shall be conducted by a member of the management team.

2) Maintain the record of this review, names of direct care providers who completed the review and the dates review was completed.

3) A member within the management team or designate Registered Nurse (RN) is to conduct daily audits that captures day and evening shifts (total of two audits for each resident per day) during a seven day period, to ensure:

-assistance with toileting is provided to identified resident;
-appropriate incontinence product is provided to identified resident;
-interventions to protect identified resident from initiating and receiving abuse are in place.

4) Maintain the record of the audits performed in a seven day period including the dates and times of the audits, name and title of the auditor(s), names and designation of the staff audited, results of audits, and actions taken.

5) All audits conducted must be made available upon request.

Grounds

1. The licensee has failed to ensure that the care set out in the plan of care for resident, related to their toileting care, was provided as specified in the plan.

Resident's plan of care stated specific directions for toileting that staff were to follow. The PSW did not follow the directions when assisting the resident which resulted in a fall, injury and transfer to hospital.

Failure to follow the plan of care for the resident, specifically in relation to toileting, placed the resident at significant risk of harm.

Sources: Critical Incident (CI) Report, resident's plan of care, interview with PSW.

2.The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

The resident, sustained a fall where it was noted that the resident did not have a fall prevention intervention applied, at the time of the fall as per the resident's written plan of care.

Sources: Resident's clinical record and interview with DOC.

3.The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. Specifically staff did not follow the plan of care with respect to the use of the correct incontinence product size for the resident.

Sources: Investigation notes and interviews with resident and Personal Support Worker.

4.The licensee has failed to ensure that interventions in resident plan of care were

applied as specified in the plan. An observation was conducted where the interventions were not in place as specified. The resident's plan of care indicated that they required these interventions to be applied to help deter co-residents from entering their room to reduce the risk of altercations.

Sources: CI report, resident's clinical records, and interview with RPN.

This order must be complied with by July 29, 2025

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
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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.