Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
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Public Report

Report Issue Date: March 3, 2026
Inspection Number: 2026-1311-0001
Inspection Type: Complaint Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care Courtland, Courtland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 19, 20, 23, 24, 25, 2026 and March 2, 3, 2026
The inspection occurred offsite on the following date(s): February 26, 2026

The following intake(s) were inspected:

- Intake: #00166911 - Critical Incident System (CIS) report #2826-000002-26 related to a disease outbreak.
- Intake: #00170381 - Complaint related to care.
- Intake: #00171012 - CIS report #2826-000004-26 related to a disease outbreak.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

Care was not provided to a resident as per their plan of care.

Sources: Review of a resident's clinical records, a written complaint; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was not implemented.

A) On two separate occasions staff were observed not wearing their surgical mask

appropriately.

Sources: IPAC observations in the home; and interviews with the IPAC Lead and the Director of Care.

B) A staff member was observed providing care to a resident who was on additional precautions, without the required PPE.

Sources: Observations in the home; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Security of Drug Supply

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

Steps were not taken to ensure the security of the drug supply in the medication and treatment carts, when the carts were not in use.

A registered nursing staff member left their medication cart unlocked and unattended in a resident home area. On another day the same staff member left their treatment cart unlocked and unattended in a resident home area.

Sources: Observations in the home; and interviews with a staff member and the Director of Care.