

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: July 16, 2025

Inspection Number: 2025-1489-0004

Inspection Type:

Critical Incident

Licensee: peopleCare Not-For-Profit Homes Inc.

Long Term Care Home and City: peopleCare A.R. Goudie Kitchener, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 9-10, 15-16, 2025.

The following intake(s) were inspected:

- Intake: #00148396: Related to an outbreak.
- Intake: #00150217: Alleged staff to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

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

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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 licensee has failed to protect a resident from verbal abuse by a staff member.

Ontario Regulation 246/22, 2 (1)(a) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A staff member was overheard raising their voice towards a resident which in turn, upset the resident.

Sources: Interview with staff, the resident's clinical records, the home's Definitions of Abuse policy, critical incident report, the home's investigative notes.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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.

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The licensee has failed to ensure that a staff member immediately reported an incident of abuse of a resident to the Director.

In accordance with FLTCA s. 154 (3), the licensee is vicariously liable when a staff member fails to comply with subsection 28 (1) 2.

A staff member overheard an incident of verbal abuse of a resident, but did not immediately report the incident to management of the home until the next day.

Sources: Interview with staff, the home's Abuse Policy, resident's clinical records, critical incident report, and the home's investigative notes.