

**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:** May 7, 2025

**Inspection Number:** 2025-1272-0002

**Inspection Type:**

Critical Incident

**Licensee:** Jarlette Ltd.

**Long Term Care Home and City:** Collingwood Care Centre, Collingwood

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-2, 5-7, 2025

The following intake(s) were inspected:

- Intake: #00141161 – CI #2781-000008-25, related to abuse
- Intake: #00144295 – CI #2781-000013-25, related to abuse

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

Prevention of Abuse and Neglect  
Responsive Behaviours

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Duty to Protect

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

**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 failed to ensure that a resident was protected from verbal abuse by a PSW.

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. ("mauvais traitements d'ordre verbal")

A PSW raised their voice to a resident.

Failure to protect the resident from verbal abuse could have affected the resident's feeling of safety and well-being and may have resulted in their sense of dignity or self-worth being impacted.

**Sources:** Interviews with Executive Director (ED) , and a Personal Support Worker (PSW) . Homes Investigation interviews, Critical Incident System report.

**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

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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.

In accordance with FLTCA s.154 (3), the licensee is vicariously liable when a staff member has not complied with subsection 28 (1) of the FLTCA.

The licensee has failed to ensure that a suspected incident of staff-to-resident abuse was reported to the Director immediately.

A PSW raised their voice to a resident. The incident was witnessed by other staff members, they did not report this to the Executive Director until seven days later.

**Sources:** Interviews with Executive Director and Personal Support Workers (PSW) , Homes Investigation interviews, Critical Incident System report.