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

Original Public Report

Report Issue Date: June 20, 2023	
Inspection Number: 2023-1158-0003	
Inspection Type: Complaint	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Cambridge Country Manor, Cambridge	
Lead Inspector Alicia Campbell (741126)	**Inspector Digital Signature** Alicia Campbell Digitally signed by Alicia Campbell Date: 2023.06.20 16:07:41 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13-16, 2023

The following intake(s) were inspected:

- Intake: #00086843, IL-12654-CW; complaint related to care of a resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that the alleged verbal and emotional abuse of a Registered Practical Nurse (RPN) to a resident was immediately reported to the Director. Pursuant to s.154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary

A Personal Support Worker (PSW) allegedly witnessed an RPN expressing inappropriate verbal and physical actions towards a resident while providing care and did not report these allegations to their superior immediately.

The Director of Care (DOC) stated that the PSW was expected to report these allegations immediately.

The failure to report the alleged verbal and emotional abuse of the resident immediately delayed the home's ability to investigate the allegations. The failure of the home to report this incident may have delayed the Director in responding to the incident.

Sources: Residents clinical records; Home's investigation notes including client services response form; RPN's employee file; Interviews with the resident and staff.

[741126]