

**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:** June 2, 2025

**Inspection Number:** 2025-1158-0003

**Inspection Type:**

Complaint

Critical Incident

**Licensee:** Caressant-Care Nursing and Retirement Homes Limited

**Long Term Care Home and City:** Cambridge Country Manor, Cambridge

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22-23 and 26-30, 2025.

The following intake(s) were inspected:

- Intake: #00146243 - complaint of alleged abuse of a resident.
- Intake: #00146249 - improper care of a resident.
- Intake: #00146948 - complaint regarding safety concerns of a resident.
- Intake: #00147284 - complaint regarding medication management of a resident.
- Intake: #00148258 - complaint regarding refusal of readmission of a resident.

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

Prevention of Abuse and Neglect  
Reporting and Complaints  
Pain Management  
Falls Prevention and Management

**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

Admission, Absences and Discharge

## 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.

The licensee has failed to ensure that the care set out in the plan of care for a resident related to their verbal responsive behaviours was provided as specified in the plan.

**Sources:** A resident's plan of care, staff schedules, a resident's medication administration record, interviews with a resident, a Registered Nurse (RN) and the Executive Director (ED).

### WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 26 (1) (c)**

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the

**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

format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint that concerned the care of a resident was immediately forwarded to the Director, including other requirements provided for in the regulations.

As per O. Reg. 246/22 s. 109 (2), additional requirements of the complaints procedure included forwarding a copy of the documented records related to the complaint.

The home had a documented record of the written complaint, including the actions that were taken to investigate the complaint, but failed to submit both pieces of information to the Director.

**Sources:** Resident's written complaint and interviews with the Executive Director (ED).

## **WRITTEN NOTIFICATION: Dealing with complaints**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.**

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be

**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

commenced immediately.

The licensee has failed to ensure that a written response was provided to a resident after receiving the written complaint and completing an investigation.

**Sources:** A resident's complaint letter, investigation records, interview with a resident and the Executive Director (ED).