DISCIPLINE COMMITTEE OF THE
COLLEGE OF NURSING OF NEW BRUNSWICK

DECISION AND REASONS
February 23, 2026

Regarding a complaint (the "Complaint") referred by the Complaints Committee respecting Cynthia (Cindy) Donovan (the "Member"), Registration Number 017802

Date of Hearing: February 9, 2026

Discipline Committee Panel: Luc Drisdelle, RN (Chairperson); Chantal Arsenault, NP (Nurse Member); Cindy Vienneau, RN (Nurse Member); Dorina S. Onge (Public Member)

Counsel:

- College of Nursing of New Brunswick (the "College") - Melissa Everett Withers
- Cynthia Donovan (the Member) - Kelly VanBuskirk, K.C., and Daniel Wilband

OVERVIEW

On February 9, 2026, a Panel of the Discipline Committee convened by videoconference. At the outset of the hearing, the parties confirmed that an Agreed Statement of Facts (the "ASF") with attached exhibits would constitute the evidentiary record for the Panel's determinations, and that the parties' legal and factual submissions would be addressed by written briefs and oral argument.

BACKGROUND

The Complaints Committee referred allegations of professional misconduct against Ms Donovan to the Discipline Committee in accordance with paragraph 29(9)(b) of the ***Nurses Act***.

The allegations are set out in the Notice of Hearing dated November 17, 2025, which is attached as Appendix A. In summary, the Notice alleges: (1) departures from established professional standards relating to client-centered practice and meeting the Resident's needs in April-May 2021 when a discharge was initiated; (2) failures in communication to promote continuity of care and assist informed decision-making by the Resident's children;

and (3) a breach of privacy and confidentiality in a letter dated June 30, 2021 sent to Facility residents and families following the Resident's discharge.

EVIDENCE

The Committee received and accepted as evidence and submissions, by consent:

- The Notice of Hearing dated November 17, 2025.
- The Agreed Statement of Facts dated 19 December 2025 (with Exhibits A-D: April 22, 2021, email correspondence; 27 April 2021 discharge letter; 7 May 2021 discharge letter; and 30 June 2021 letter to Facility residents and families).
- The College's Brief on Merits.
- The Respondent's Brief on Law.

FACTS AND ADMISSIONS

As set out in the evidentiary record filed by the parties:

1. At all relevant times, the Member was a duly registered member of the College and served as Chief Executive Officer at Loch Lomond Villa in Saint John, New Brunswick. An 83-year-old female with dementia (the "Resident") resided at the Facility from October 2019 to May 22, 2021.
2. By April 2021, the relationship between the Resident's children and Facility staff had deteriorated. On April 22, 2021, in response to concerns, Ms Donovan emailed the Resident's children offering: (a) that they take the Resident home for 30 or more days; or (b) if not feasible, that the Facility would facilitate transfer to another nursing home. The children sought clarification the same day. This correspondence was produced to the Panel as part of the evidentiary record.
3. After consultation with the Facility's Board of Directors and the Department of Social Development, the Member issued a discharge notice on April 27, 2021, to the Resident's children, notifying them that the Resident would be discharged from the Facility in 15-days, in accordance with the ***Nursing Homes Act***. restarting a 15-day timeline (Exhibit B). There was no communication between Ms. Donovan and the children between April 22 and April 27, 2021. Following a response from the children's counsel, a further discharge letter dated May 7, 2021 was provided, which included reasons for the discharge and notice that the 15-day timeline had been restarted.

4. It was the responsibility of the Resident's children to arrange for the Resident's transfer to another nursing home of their choice. On and after May 19, 2021, there were conflicting communications regarding placement, and the Resident was ultimately transferred to hospital to ensure continuity of care.
5. In May-June 2021, the Resident's children generated significant media attention about the discharge (including CBC interviews and Facebook posts). After obtaining advice from a marketing/communications firm and legal counsel, the Member sent a letter on June 30, 2021, to all Facility residents and families acknowledging a discharge and underscoring the Facility's commitment to a safe and respectful environment. The Resident was not named in the letter.

In the ASF as filed, the Member admits to the truth of the facts set out therein, and acknowledges that those facts, taken at their highest, do not constitute professional misconduct as alleged.

SUBMISSIONS OF THE PARTIES

The College submitted that the agreed upon facts demonstrates: (1) a failure to respect the Resident's best interests and to ensure professional behaviours met the Resident's needs; (2) failures of effective and respectful communication to promote continuity of care and to assist the Resident's children in making informed decisions; and (3) a breach of privacy and confidentiality by sending the June 30, 2021 letter, which contained "identifying information" in the circumstances. The College maintained that client privacy obligations are not waived or reduced by a client's or family's public disclosures. The College argued that Ms. Donovan digressed from and failed to meet the NANB ***Standards of Practice for Registered Nurses***, the NANB ***Standards for the Nurse-Client Relationship***, and the Canadian Nurses Association's 2017 ***Code of Ethics for Registered Nurses***.

The Member submitted that: (1) decisions about admission and discharge are the statutory responsibility of the nursing home operator under the ***Nursing Homes Act*** and its regulations; (2) Ms Donovan, acting as CEO and agent of the operator, was not in a nurse-client relationship with the Resident; and (3) in any event, the ASF does not show a clear, cogent and compelling departure from established nursing standards, and the June 30, 2021 letter did not disclose personal health information and responded narrowly to a public controversy instigated by the family.

ISSUES

The Panel addressed the allegations as pleaded:

- Allegation 1: Did the Member depart from standards relating to client-centered practice and meeting the Resident's needs in connection with the discharge process.
- Allegation 2: Did the Member fail in her communications with the Resident and her children to promote continuity of care and to assist the Resident's children to make informed decisions, and in ending any nurse-client relationship.
- Allegation 3: Did the Member breach the privacy and confidentiality of the Resident in sending the June 30th, 2021 letter.

DECISION

Having considered the ASF, the exhibits, and the parties' submissions, the Panel finds as follows:

- Allegations 1 and 2 as set out in the Notice of Hearing have not proven on a balance of probabilities. As such, the Panel makes no findings with regard to these allegations.
- Allegation 3 as set out in the Notice of Hearing has been proven on a balance of probabilities.

REASONS

Allegations 1 and 2

The Panel's assessment is grounded in the ASF and exhibits, which constitute the entirety of the evidentiary record. The ASF records that the April 27 and May 7, 2021, discharge communications followed the Member's consultation with the Facility's Board and the Department of Social Development and were issued by her as CEO, in a manner that was consistent with the governing legislation. The ASF also confirms that on April 22, 2021, prior to the discharge letters, alternatives were canvassed with the Resident's children, including a community-based plan or facilitated transfer to another nursing home. There was no intervening communication between April 22 and 27, 2021 before the first discharge notice was issued.

On this record, the Panel is not satisfied that the College has established that the Member, in the circumstances and role described by the ASF, digressed from established nursing standards relating to client-centered practice or failed in her professional obligations to meet the Resident's needs. The ASF demonstrates that options were offered on April 22, 2021, that further reasons were provided on May 7, 2021, and that continuity of care was maintained through hospital transfer when arrangements remained conflicting or

uncertain. Considering the agreed facts and exhibits filed, the Panel is not persuaded that the Member engaged in misconduct as alleged in allegations 1 and 2.

Allegation 3

The Panel is satisfied that the College has proven that the Member failed to uphold and protect client privacy and confidentiality by sending the June 30, 2021 letter to all Facility residents and families following the Resident's discharge. Although the Resident was not named, the ASF confirms significant contemporaneous media coverage created by the family regarding the discharge and that the letter expressly referenced the relocation of a resident. In these circumstances, the content of the June 30, 2021 letter, coupled with the contemporaneous public information, rendered it reasonably foreseeable that the Resident and her family could be identified. The obligation to safeguard client information-particularly around sensitive care transitions-remains with the nurse and is not displaced by third-party publicity.

The Member's position that any privacy interest was effectively waived by the family's public disclosures does not, on this record, overcome the nurse's ongoing duty to avoid disclosing, confirming, or amplifying client-specific information in communications to a broader community audience. Even accepting that reputational concerns within the Facility justified a general communication, the inclusion of content that made identification reasonably foreseeable constituted a failure to safeguard the Resident's personal and family information in the context of a professional relationship.

Accordingly, the Panel finds that the Member engaged in professional misconduct as alleged in allegation 3.

ORDER

Having found Allegation 3 proven and Allegations 1 and 2 not proven, and based on the submissions from counsel, the Panel finds that a remedial, educational response to the misconduct is appropriate and proportionate in the public interest. The Panel therefore orders that, within 60 days of the release of this Decision and Reasons, and at her own expense, the Member must successfully complete the following Canadian Health Information Management Association (CHIMA) courses and provide proof of completion to the College:

1. 0062 Privacy Awareness - course fee estimated at $119.
2. 0127 Privacy and Confidentiality in Health Care - course fee estimated at $20.

The Panel finds that the imposition of further orders is not proportionate in the circumstances and that there should be no order as to costs.

ORDER

Based on the evidence and in consideration of the above, the Panel makes the following order:

1. Allegations 1 and 2 in the Notice of Hearing are dismissed.
2. Allegation 3 in the Notice of Hearing is proven.
3. As a condition on the Member's registration, within sixty (60) days of the release of this Decision and Reasons, and at her own expense, she shall complete the CHIMA courses 0062 Privacy Awareness and 0127 Privacy and Confidentiality in Health Care and provide satisfactory proof of completion to the College.

Dated this 23rd day of February 2026.

Signed by

Luc Drisdelle, RN, Chairperson

Signed by

Chantal Arsenault, NP, Nurse Member

Signed by

Cindy Vienneau, RN, Nurse Member

Signed by

Dorina S. Onge, Public Member

DISCIPLINE COMMITTEE OF THE

NURSES ASSOCIATION OF NEW BRUNSWICK

BETWEEN:

NURSES ASSOCIATION OF NEW BRUNSWICK

And

CYNTHIA DONOVAN
Registration number 017802

NOTICE OF HEARING

THE COMPLAINTS COMMITTEE of the Nurses Association of New Brunswick ("NANB") has referred the complaint against you to the Discipline Committee of NANB. The complaint was referred in accordance with paragraph 29(9)(b) of the ***Nurses Act***. The allegations relating to the complaint are outlined in this Notice of Hearing. A panel of the Discipline Committee (the "**Panel**") will hold a hearing under the authority of section 30 of the ***Nurses Act*** for the purposes of deciding whether the allegations are true and whether you committed acts of professional misconduct.

ALLEGATIONS

IT IS ALLEGED THAT:

1. In or about April, May, and June, 2021, you committed acts of professional misconduct as defined in subsection 2(1) of the ***Nurses Act*** in that, while working as a Registered Nurse at Loch Lomond Villa (the "**Facility**"), you digressed from established or recognized professional standards or rules of practice of the profession, including but not limited to the NANB ***Standards of Practice for Registered Nurses*** and the NANB ***Standards for the Nurse-Client Relationship***, as follows:

    a. On or about April 27, 2021, you sent a notice to the family of an 83-year-old resident with dementia and confusion (the "**Resident**") that the Resident would be discharged from the Facility without having first employed any alternatives to discharge with the Resident's best interest in mind, and without providing a written warning to the Resident's family that the Resident may be discharged from the Facility. By discharging the Resident without employing alternate measures, you failed to ensure that all professional behaviours and actions met the needs of the Resident, and/or you failed to practice using a client-centered practice as required by standard 1 of the NANB ***Standards for the Nurse-Client Relationship*** and standard 3.5 of the NANB ***Standards of Practice for Registered Nurses***.

b. On or about April 22, 2021, you asked the Resident's family by email if they wished to take the Resident home for 30 or more days to care for her in the community, and you stated that if this option was not feasible, the Facility would facilitate the Resident's transfer to another nursing home. Although the Resident's family replied by email dated April 22, 2021 to say they were seeking clarification regarding your suggested accommodation options for the Resident, you sent the above-noted notice of discharge on April 27, 2021, which provided insufficient time for the Resident's family to assess their ability to care for the Resident and/or to make inquiries with other nursing homes about accepting the Resident into their care.

   i. By discharging the Resident without employing alternate measures, you failed to ensure that all professional behaviours and actions met the needs of the Resident, and/or you failed to practice using a client-centered practice as required by standard 1 of the NANB ***Standards for the Nurse-Client Relationship*** and standard 3.5 of the NANB ***Standards of Practice for Registered Nurses***.

   ii. By failing to provide sufficient time for the Resident's family to consider and respond to your offer, you failed to communicate effectively with the Resident's family to promote continuity and the delivery of safe, competent, compassionate and ethical care to the Resident; and/or you failed to maintain and terminate the nurse-client relationship; and/or you failed to support the Resident and her family by providing information, resources and referrals for them to make informed decisions and access appropriate health care services for the Resident as required by standards 3.2 and 3.6 of the NANB ***Standards of Practice for Registered Nurses*** and standard 3 of the NANB ***Standards for the Nurse-Client Relationship***.

c. Following the notice of discharge letter dated April 27, 2021, you sent a second notice of discharge letter to the Resident's family on or about May 7, 2021. Other than these two letters, you failed to communicate with the Resident's family about the Resident's discharge and her transfer to another institution. Facility staff members contacted the Resident's family the day before her discharge and on May 22, 2021 as the Resident was being discharged. In this regard, you failed to communicate effectively with the Resident's family to promote continuity and the delivery of safe, competent, compassionate and ethical care to the Resident as required by standard 3.2 of the NANB ***Standards of Practice for Registered Nurses***.

d. Following the Resident's discharge from the Facility, you sent a letter dated June 30, 2021 to all Facility families about the Resident's discharge. Although your letter did not include the Resident's name, the letter included information which could be utilized, either alone or with other information, to identify the Resident and her family. In this regard, you failed to uphold and protect the Resident's and her family's privacy and confidentiality in all forms of communication as required by standard 3.4 of the NANB ***Standards of Practice for Registered Nurses***.

2. In or about April and May, 2021, you contravened Part I, section C 10 of the Canadian Nurses Association's ***Code of Ethics for Registered Nurses*** in that you failed to consider and respect, along with substitute decision-makers, the best interests of the person receiving care, as follows:

    a. On or about April 27, 2021, you sent a notice to the Resident's family that the Resident would be discharged from the Facility without having first employed any alternatives to discharge with the Resident's best interest in mind, and without providing a written warning to the Resident's family that the Resident may be discharged from the Facility.

    b. On or about April 22, 2021, you asked the Resident's family by email if they wished to take the Resident home for 30 or more days to care for her in the community, and you stated that if this option was not feasible, the Facility would facilitate the Resident's transfer to another nursing home. Although the Resident's family replied by email dated April 22, 2021 to say they were seeking clarification regarding your suggested accommodation options for the Resident, you sent the above-noted notice of discharge on April 27, 2021, which provided insufficient time for the Resident's family to assess their ability to care for the Resident and/or to make inquiries with other nursing homes about accepting the Resident into their care.

3. On or about June 30, 2021, you contravened Part I, sections E 3, 4, and 5 of the Canadian Nurses Association's ***Code of Ethics for Registered Nurses*** in that you failed to safeguard personal and family information obtained in the context of your professional relationship, in that following the Resident's discharge from the Facility, you sent a letter dated June 20, 2021 to all Facility families about the Resident's discharge. Although your letter did not include the Resident's name, the letter included information which could be utilized, either alone or with other information, to identify the Resident and her family.

The allegations respecting professional misconduct on your part will be heard by the Panel pursuant to subsection 30(6)(a) of the ***Nurses Act*** on the **9th and 13th (if required) days of February 2026, at 10:00 a.m. (Atlantic)**, via electronic hearing by way of videoconference, pursuant to Rule 4.03(1) of the Discipline Committee Rules of Procedure. The details for participating in the hearing will be provided to you in advance of the hearing. The hearing will be conducted in English.

At least 48 hours before the hearing is scheduled to commence, you must provide NANB with the email address where you can be reached for the hearing.

IF YOU DO NOT ATTEND AT THE HEARING IN ACCORDANCE WITH THE PRECEDING PARAGRAPHS, THE PANEL MAY PROCEED IN YOUR ABSENCE PURSUANT TO PARAGRAPH 11.17(D) OF THE NANB BYLAWS AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE IN THE PROCEEDINGS.

PURSUANT TO SUBSECTION 30(8) OF THE *NURSES ACT*, if the Panel finds that you have committed one or more acts of professional misconduct, it may make an Order of any one or more of the following:

1. Revoking your registration;
2. Suspending your registration for a specific period of time;
3. Suspending your registration pending completion of such conditions as may be ordered by the Panel;
4. Ordering that conditions or restrictions be imposed on your registration;
5. Issuing a reprimand;
6. Imposing a fine not exceeding $1,000; and/or
7. Making such other order as it deems just.

PURSUANT TO SUBSECTION 41(1)(a) OF THE *NURSES ACT*, if the Panel finds that you have committed one or more acts of professional misconduct, it may make an Order requiring you to pay all or part of the following costs and expenses:

1. NANB's legal costs and expenses;
2. NANB's costs and expenses incurred in investigating the Complaint; and
3. NANB's costs and expenses incurred in conducting the hearing.

YOU ARE ENTITLED to disclosure of the evidence against you in accordance with Rules 7.01(2) and (3) of the Discipline and Fitness to Practice Committee Rules of Procedure. You, or your representative, may contact the lawyer for NANB. Their name and contact information is:

Melissa M. Everett Withers
Director of Complaints & General Counsel
Nurses Association of New Brunswick
165 Regent Street
Fredericton, NB E3B 7B4
mewithers@nanb.nb.ca

YOU ALSO HAVE disclosure obligations under Rules 7.01(2) and (3) of NANB's Discipline and Fitness to Practice Committee Rules of Procedure which provide, in part, that each party shall deliver to every other party, in advance of the hearing, copies of all documents and things upon which the party intends to rely at the hearing. At least 45 days before the scheduled hearing date, you are required to disclose to NANB any document or thing upon which you intend to rely at the hearing.

Date: November 17, 2025

Signed by
Kate Sheppard, RN, MN
Interim CEO & Registrar
Nurses Association of New Brunswick

TO: CYNTHIA DONOVAN
c/o Daniel Wilband / Kelly VanBuskirk
VanBuskirk Law
1 Germain Street, 12th Floor
Saint John, NB E2L 4V1
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APPENDIX A

1. The documents to be tendered in evidence at the hearing have been sent separately.
2. Take notice that documents that have been or will later be disclosed to you will be tendered as business documents pursuant to section 49 of the *Evidence Act*, RSNB 1973, c. E-11.
3. All documents that are disclosed to you in this matter are disclosed on the basis that they are to be used solely for the purpose of this proceeding and for no other purpose.