Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: October 25, 2023	
Inspection Number: 2023-1195-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Coleman Care Centre, Barrie	
Lead Inspector Gabriella Del Principe (741734)	**Inspector Digital Signature**
Additional Inspector(s) Kim Byberg (729)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 11-12, 16-20, 2023.

The following intake was inspected:

- Intake #00098861, Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

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INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 20 (a)

The licensee failed to ensure that two residents call bells were easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary
A) One resident's call bell was observed behind their side table. The call bell was pinned under the table and a staff member had to move the table to access the call bell.

A Personal Support Worker (PSW) stated that call bells should be clipped to the bed and accessible to everyone.

Sources: Inspector #729’s observation; Interview with a PSW.

B) A second resident was sitting beside their bed in their wheelchair. They did not have access to their call bell as it was on the floor, under the bed on the opposite side from where they were sitting.

A PSW stated that call bells should be clipped to the bed and reachable for everyone.

The residents were at risk when their call bells were on the floor and not accessible.

Sources: Inspector #729’s observation; Interview with a PSW. [729]

Date Remedy Implemented: October 11, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 79 (1) 8.

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The licensee failed to ensure that a resident was provided with assistive devices to promote independence during mealtime.

Rationale and Summary

A resident's care plan indicated that they were to receive assistive devices at mealtime to promote independence while eating.

The resident was observed eating without the use of assistive devices and a staff member was providing assistance as required.

A Food Service Worker (FSW) and the Director of Food Services (DFS) were informed, and the resident was provided with the assistive devices at the following meal service.

Failing to provide the resident with assistive devices at mealtime prevented them from eating as independently as possible.

Sources: Resident's clinical health records; Inspector #741734's observations; Interviews with FSW and the DFS. [741734]

Date Remedy Implemented: October 12, 2023