

**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:** October 21, 2025

**Inspection Number:** 2025-1195-0004

**Inspection Type:**

Critical Incident

**Licensee:** Schlegel Villages Inc.

**Long Term Care Home and City:** Coleman Care Centre, Barrie

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 20, 21, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:

-Intake: #00157342, related to Continence care

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

Continence Care

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Nursing and personal support services

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

**Non-compliance with: FLTCA, 2021, s. 11 (1) (a)**

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Nursing and personal support services

s. 11 (1) Every licensee of a long-term care home shall ensure that there is,  
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

The licensee has failed to ensure that there was an organized program of nursing services for the home to meet the assessed needs of a resident.

In accordance with O. Reg 246/22 s.11 (1) (b), the licensee is required to ensure the organized program of nursing services is complied with. Specifically, a continence procedure.

A resident was ordered a diagnostic test however, there was a delay in collecting the sample. During the collection, a staff member followed a step that was not included in the procedure. The resident sustained an injury.

**Sources:** Resident's health record, the home's policy (04-24), interview with staff

**WRITTEN NOTIFICATION: Reports re critical incidents**

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

**Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.**

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

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The licensee has failed to ensure that an unexpected death of a resident was immediately reported to the Director.

**Sources:** CIS Report, progress note, interview with staff