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
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Public Report

Report Issue Date: April 30, 2026
Inspection Number: 2026-1272-0003
Inspection Type: Complaint Critical Incident
Licensee: Jarlette Ltd.
Long Term Care Home and City: Collingwood Care Centre, Collingwood

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22 – 24, 27 - 30, 2026

The following intake(s) were inspected:
-Intake #00169489: complaint related to care concerns.
-Intake #00170526: related to allegations of resident abuse.
-Intake #00171885: complaint related to medication concerns.
-Intake #00176518: related to falls prevention and management.

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

Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. i.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of

residents are fully respected and promoted:
19. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of their plan of care,

A resident repeatedly expressed concerns related to their medications to the home; however, their concerns were not addressed.

Sources: Resident's Clinical Records, Interview with Resident and the Nurse Practitioner.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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.

A resident's plan of care required a specified amount of physiotherapy each week; however, the resident did not receive physiotherapy for multiple weeks.

Sources: Resident's clinical record, Interview with resident and Discussion with the Executive Director.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has

occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Staff members did not immediately report suspected alleged abuse of a resident to the home.

Sources: Interviews with staff, Investigation documents.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

A nurse did not complete a skin assessment after a staff member reported a new bruise on a resident.

Sources: Interviews with staff, Investigation documents, Skin & Wound Policy.