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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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: April 11, 2025

Inspection Number: 2025-1492-0003

Inspection Type:
Critical Incident
Follow up

Licensee: IOOF Seniors Homes Inc.

Long Term Care Home and City: IOOF Seniors Home, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 7 - 11, 2025

The following intake(s) were inspected:

- Intake: #00139206 - Fall Prevention
- Intake: #00139342 - Compliance Order Follow-up
- Intake: #00139805 - Infection Prevention and Control
- Intake: #00140816 - Prevention of Abuse / Responsive Behaviours

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1492-0002 related to O. Reg. 246/22, s. 140 (1)

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

Medication Management
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's care plan was reviewed and revised when the resident was reassessed and their care needs changed.

The resident's plan of care was not updated after a Registered Practical Nurse (RPN) was notified that the resident's care needs related to transferring and mobility had changed. The RPN acknowledged the changes had not been updated in the resident's plan of care and indicated the changes would be made immediately. The resident's care plan was updated shortly after to reflect the current interventions in place with regards to their transfer and mobility statuses.

Sources: Record review of resident #001's clinical records; resident observations; and interview with Registered Practical Nurse (RPN) #101.

Date Remedy Implemented: April 8, 2025