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: January 16, 2026
Inspection Number: 2026-1492-0001
Inspection Type: Critical Incident
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): January 8, 9, 13 - 16, 2026

The following intake(s) were inspected:

- Intake: #00159812 and #00160491 – Falls Prevention and Management
- Intake: #00160451 – Prevention of Abuse and Neglect

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

Prevention of Abuse and Neglect
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 (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.

Ministry Long Term Care Inspector observed that an intervention was not in place for a resident as set out in the resident's care plan.

Sources: Observations, resident's clinical records and interviews with staff.

Date Remedy Implemented: January 14, 2026

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A resident was not protected from emotional abuse by staff, specifically in relation to allegations brought forward by registered staff.

Section 2 of the Ontario regulation 246/22 defines emotional abuse as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident”.

Two Personal Support Workers were seen exhibiting inappropriate behaviours toward a resident. The resident responded with responsive behaviours. The actions were immediately stopped by registered staff, who reported the incident to the home.

Source: Critical Incident Report, investigation Notes, clinical records and interviews with staff.