

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 16, 2022	2022_901759_0004	017002-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Owen Hill Care Community
130 Owen Street Barrie ON L4M 3H7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KEARA CRONIN (759)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 7-10, 2022, and offsite on February 11 and 14, 2022.

**The following intake was inspected during this Critical Incident System inspection:
- One intake related to an alleged resident to resident abuse.**

A Follow-Up inspection #2022_901759_0003 and a Complaint inspection #2022_901759_0002 were conducted concurrently with this inspection

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant health care records, and reviewed licensee policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.**
- 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.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.**

Findings/Faits saillants :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse of a resident, that resulted in harm to the resident, immediately reported the suspicion to the Director.

Pursuant to s. 152 (2) the licensee was vicariously liable for staff members failing to comply with subsection 24 (1).

An incident occurred involving three residents, and one of the residents sustained an injury. The incident was not reported to the Director until the following day.

The DOC acknowledged that the incident was not reported to the Director until the following day.

Sources: a Critical Incident System (CIS) Report; three residents' clinical records; the policy titled "Prevention of Abuse and Neglect" last revised April 2021; and interviews with the DOC, and other relevant staff. [s. 24. (1) 2.]

Issued on this 18th day of February, 2022

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.