Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
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Original Public Report

Report Issue Date: January 30, 2024	
Inspection Number: 2024-1098-0001	
Inspection Type: Critical Incident	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Owen Hill Community, Barrie	
Lead Inspector Mark Molina (000684)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22-25, 2024

The following intake(s) were inspected:

- Intake: #00097169 - related to a resident fall
- Intake: #00104658 - related to a resident to resident altercation

The following intake(s) were completed in this inspection:

- Intake: #00093150 - related to a resident fall

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 has failed to ensure a resident's plan of care was revised when the resident's care needs changed and care set out in the plan was no longer necessary.

Rationale and Summary
A resident's care plan stated that they had interventions for responsive behaviours. The resident was observed to not have the interventions in place.

A staff member stated that the resident no longer required the interventions. The Associate Director of Care (ADOC) stated that the care plan should have been

updated to reflect this.

Failure to update the plan of care when a resident's needs changed, put the resident at risk for receiving care that was no longer necessary.

Sources: Resident's clinical records, Observations of a resident and their room, Interviews with staff
[000684]

WRITTEN NOTIFICATION: Duty To Protect

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.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 (1) (b) of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by another resident that causes physical injury to another resident.

Rationale and Summary
Staff witnessed two residents having a verbal and physical altercation. When the residents were approached by staff, it was discovered that one of the residents sustained a physical injury.

Failure to protect a resident from physical abuse, resulted in them sustaining a

physical injury.

Sources: Residents' clinical records, Interviews with staff
[000684]

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.

The licensee has failed to immediately report an incident to the Director, when a resident was physically abused by another resident.

Rationale and Summary
A resident sustained a physical injury after an altercation with another resident.

A critical incident (CI) report was submitted to the Director one day after the incident occurred.

The ADOC acknowledged that the incident should have been reported the day that it occurred.

The home's failure to immediately report the incident of abuse may have delayed

the Director in responding to the incident.

Sources: Residents' clinical records, CI report, Interview with staff
[000684]