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
Telephone: (888) 432-7901

Public Report

Report Issue Date: February 25, 2025

Inspection Number: 2025-1098-0001

Inspection Type:
Critical Incident
Follow up

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Owen Hill Community, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20-21, 24-25, 2025

The following intake(s) were inspected:

- Intake #00132098 - Follow-up #1 - FLTCA, 2021 - s. 19 (1) (c)-Follow-up to CO #001 from inspection 2024-1098-0004, CDD Dec 31, 2024.
- Intake #00133626, CI #2584-000016-24 - regarding staff to resident abuse.
- Intake #00134439, CI #2584-000017-24 - regarding the fall of a resident resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1098-0004 related to FLTCA, 2021, s. 19 (1) (c)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 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 ensure that the witnessed abuse of a staff member to a resident was immediately reported to the Director. Pursuant to s.154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

A student allegedly witnessed an incident between a staff member and a resident during care. When the student did not report the alleged witnessed abuse immediately, the staff member continued to work with the resident for the rest of their shift. This put the resident's safety at continued risk.

Sources: CI #2024-000016-24, The Home's internal investigation, interviews with

staff.

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WRITTEN NOTIFICATION: Safe storage of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that drugs were stored in a medication cart that was secure and locked.

The medication cart on the third floor was found unlocked in the hallway. The registered staff member responsible for monitoring or locking the medication cart was in a residents room.

Sources: Observation and discussion with staff.

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