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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: July 15, 2025
Inspection Number: 2025-1315-0004
Inspection Type: Complaint Critical Incident
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Barnswallow Place Community, Elmira

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3, 7-11, 14 -15, 2025

The following intake(s) were inspected:

Intake: #00147061 - Related to an outbreak.
Intake: #00148355 - Related to fall of a resident.
Intake: #00148387 - Related to an outbreak.
Intake: #00148830 - Related to allegation of improper care of a resident.
Intake: #00149365 - Related to allegation of improper care of a resident.
Intake: #00149361 - Concerns regarding care of a resident.

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

Continence Care
Medication Management
Infection Prevention and Control
Responsive Behaviours

Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's Power of Attorney (POA) was provided an opportunity to participate fully in the development and implementation of the resident's plan of care on multiple occasions.

Sources: Interview with staff, resident's clinical notes.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director

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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 an incident of suspected staff to a resident abuse or neglect was immediately reported to the Director.

sources: Review of critical Incident , interview with staff, review of the resident's medical records.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that, a resident who required continence care products, received sufficient changes to remain clean, dry and comfortable on a specific day.

Sources: Review of the resident's medical records, interview with the resident and staff.