

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

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

Public Report

Report Issue Date: December 18, 2025

Inspection Number: 2025-1315-0006

Inspection Type:

Complaint
Critical Incident

Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited

Long Term Care Home and City: Barnswallow Place Community, Elmira

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 9-11, 16-18, 2025

The inspection occurred offsite on the following date(s): December 12, 15, 2025

The following intake(s) were inspected:

- Intake: #00160097, #00162151, #00164059 related to prevention of abuse and neglect of a resident
- Intake: #00162422 - Complainant related to resident care concerns
- Intake: #00163156 -related to safe and secure home

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

Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Duty to protect

NC #001 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.

Emotional abuse” means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident

A resident displayed responsive behaviour towards a staff. The staff responded with inappropriate gestures and actions.

Sources: review of a resident's clinical records, interviews with staff

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

A) The home's Abuse and Neglect of a Resident policy was not complied with..

The policy directed the home to immediately notify the police and the resident's Substitute Decision Maker (SDM) after an incident of suspected or alleged abuse/neglect. This was not complied with.

Sources: policy review and interview with staff

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B) The home's Abuse and Neglect of a Resident policy was not complied with.

The policy directed the home to immediately assess a resident for physical wellbeing, report to the police alleged resident abuse and remove alleged abuser from resident. These did not occur immediately.

Sources: policy review and interview with staff

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) 1.

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A) There were allegations related to suspected improper or incompetent treatment or care to residents that were not reported immediately to the Director.

Sources: interviews with staff, home documentation

B) The home did not report an allegation of incompetent care for a resident.

Sources: interview with staff and home's documentation

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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

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resulted in harm or a risk of harm to the resident.

The home did not report an allegation of staff to resident abuse of a resident.

Sources: interviews with staff, home's documentation

WRITTEN NOTIFICATION: Bed rails

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

Bed rails

s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

A resident did not have a bed safety assessment completed.

Sources: policy review and interviews with staff

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Manufacturer guidelines were not followed for trouble shooting when a resident's equipment did not function.

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Sources: Review of a resident clinical records, interviews with staff and manufacturer's guidelines for the equipment

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

A staff member did not complete an assessment for a resident as required by the home's policies.

Sources: policy review, interviews with staff, review of a resident's clinical record

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

A written complaint related to care of a resident was not immediately investigated. A response was not provided to the complainant with the outcome of the home's investigation within 10 business days.

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Sources: critical incident and interview with staff

WRITTEN NOTIFICATION: Complaints-reporting certain matters to Director

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 111 (1)

Complaints — reporting certain matters to Director

s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

A written complaint related to care of a resident was not immediately forwarded to the Director.

Sources: after hours and critical incident, interview with staff



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

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