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

Public Report

Report Issue Date: February 11, 2026
Inspection Number: 2026-1315-0001
Inspection Type: 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): February 2 - 5, 10 and 11, 2026

The following intake(s) were inspected:
-Intake: #00165815: Related to Falls Prevention and Management and Medication Management.
-Intake: #00166618 and Intake: #00167753: Related to the Prevention of Abuse and Neglect.
-Intake: #00169009: Related to Skin and Wound Prevention and Management.

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

Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Responsive Behaviours
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) 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.

The home discovered an incident of suspected improper care of resident and it was not immediately reported to the Director.

Sources: Critical incident report, Interview with staff, the homes investigation file.

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #002 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.

On a specified date, a resident had an unwitnessed fall and a staff member did not initiate a required assessment in a timely manner.

Source: Critical incident report, Falls Prevention & Management Policy, VII-G-30.10, clinical records, investigation notes and interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

A resident had a dressing on a wound that was ordered to be changed every two days. On a specified date, staff discovered the dressing had not been changed as ordered.

Sources: Resident clinical records, the home's investigation record, Interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

A resident had a wound that was not assessed weekly as required.

Sources: A resident's clinical records, Interviews with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

A physical altercation occurred between two residents when staff did not intervene.

Sources: Critical incident report, Resident's clinical records, Interview with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

a.) A staff did not follow the orders laid out for a resident's blood glucose checks and medications.

Source: Critical incident report, investigation notes, clinical records and interviews with staff.

b.) A staff did not administer scheduled medication to a resident.

Source: Critical incident report, investigation notes, clinical records, Interviews with staff.

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