

Ministry of Long-Term Care

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

North District

159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: July 31, 2025

Inspection Number: 2025-1320-0005

Inspection Type:

Complaint
Critical Incident

Licensee: Orillia Long Term Care Centre Inc.

Long Term Care Home and City: Leacock Care Centre, Orillia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 28-31, 2025.

The following intake(s) were inspected:

- Two Intakes related to residents having sustained falls; and,
- One Intake related to a complaint submitted to the Director regarding the care of a resident.

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

Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided as specified in the plan.

Sources: Inspector observation; a resident's plan of care, Point-Of-Care (POC) documentation, and assessments, Critical Incident (CI) report; and, interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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.

The licensee has failed to ensure that when the care needs for a resident changed, the plan of care was revised.

Sources: Review of a resident's plan of care; and, interviews with staff.

WRITTEN NOTIFICATION: Strategies to Prevent Falls

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NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the strategies used to reduce or mitigate falls for a resident, including the implementation of restorative care approaches, and the use of equipment, supplies, devices and assistive aids were accurately identified and followed in the plan of care.

A resident had a significant change in status, and prevention interventions were added according to the progress notes.

The plan of care did not accurately identify the equipment, supplies, devices and assistive aids that the staff were using with the resident.

Sources: Inspector observations; a resident's plan of care, progress notes, and, assessments, CI report; and interviews with staff.

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