

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

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

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 16, 2022	2022_901759_0002	000854-22	Complaint

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**Licensee/Titulaire de permis**

2063414 Ontario Limited as General Partner of 2063414 Investment LP  
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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**Long-Term Care Home/Foyer de soins de longue durée**

Owen Hill Care Community  
130 Owen Street Barrie ON L4M 3H7

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

KEARA CRONIN (759)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): February 7-10, 2022, and offsite on February 11 and 14, 2022.**

**The following intake was inspected during this Complaint inspection:**

**- One intake related to care concerns of a resident.**

**A Follow-Up inspection #2022\_901759\_0003 and a Critical Incident System inspection #2022\_901759\_0004 were conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physicians, Resident and Family Experience Coordinator (RFC), Director of Resident Programs, Registered Dietitian (RD), Physiotherapist (PT), and residents.**

**The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant health care records, and reviewed licensee policies and procedures.**

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

**Continence Care and Bowel Management**

**Hospitalization and Change in Condition**

**Nutrition and Hydration**

**Personal Support Services**

**Reporting and Complaints**

**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**

**2 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services**

**Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,**

- (a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and**
- (b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that Occupational Therapy was available for residents in the home who required it.

There was no Occupational Therapist available to conduct assessments of residents, including wheelchair assessments, for a period of time.

The ED indicated that it had been difficult to secure an Occupational Therapist and that residents did not have access to an Occupational Therapist for a period of time.

Sources: email communications between the home and service provider; and interviews with the ED, and other staff. [s. 59. (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include, occupational therapy, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

- s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
- (a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
  - (b) is on at all times; O. Reg. 79/10, s. 17 (1).**
  - (c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
  - (d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
  - (e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
  - (f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
  - (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident had access to the resident-staff communication response system at all times.

A resident was not able to reach their call bell and was found by an RN.

The RN indicated that the resident was not able to reach their call bell and that it was distressing to the resident that they did not have access to the call bell.

Sources: A resident's clinical records; interviews with and RN and other staff members.  
[s. 17. (1) (a)]

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**Issued on this 18th day of February, 2022**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**