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 Service Area Office
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Original Public Report

Report Issue Date: September 29, 2022	
Inspection Number: 2022-1315-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Barnswallow Place Care Community, Elmira	
Lead Inspector Robert Spizzirri (705751)	**Inspector Digital Signature** Robert Spizzirri Digitally signed by Robert Spizzirri Date: 2022.09.30 10:16:16 -04'00'
Additional Inspector(s) Katherine Adamski (753) Lillian Akapong (741771)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 21-23, and 26-28 of 2022

The following intake(s) were inspected:

- Intake: #00002070 (Complaint) related to abuse, infection prevention and control, care and support services, continence care, and fall prevention.
- Intake: #00005282 (Complaint) related to falls prevention and management.
- Intake: #00007654 (Critical Incident) related to fall prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

Resident Care and Support Services
Continence Care
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Personal items and personal aids

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

Non-compliance with: O.Reg. 246/22, s. 41. (1) (b)

The licensee has failed to ensure that two resident's wheelchairs were cleaned as required in the home.

Rationale and Summary

Two resident's wheelchairs were visibly soiled with dirt, dried food and liquids, particles and crumbs, and smudges of unknown substances.

A staff member said that wheelchairs were not cleaned properly.

Staff were expected to clean wheelchairs, at minimum, once a week and document the completion of the task. According to the home's wheelchair cleaning documentation, one resident's wheelchair was not cleaned during the months of August and September 2022. Another resident's wheelchair was not cleaned for the year of 2022.

The Director of Care (DOC) acknowledged that the wheelchairs had not been cleaned as required.

A safe and clean environment was not provided to two residents when their wheelchairs were not cleaned as required.

Sources: Observation of resident's wheelchairs, Wheelchair Cleaning Documentation, and interviews with the DOC and other staff.

[705751]