Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2020	2020_805638_0017	021975-20, 023277-20	Complaint

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Roberta Place
503 Essa Road Barrie ON L4N 9E4

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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 7 - 11, 2020.

The following intakes were completed as a result of this complaint inspection;
-One log which was related to a complaint regarding housekeeping services and resident care; and
-One log which was related to a complaint regarding laundry services, linen and equipment availability.

Please note: A follow up inspection (#2020_805638_0016) was conducted concurrently with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Food Service Manager (FSM), Restorative Care Coordinator (RCC), Registered Dietitian, Staff Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, residents and their families.

The Inspectors also conducted daily tours of resident care areas, reviewed relevant health care records, incident reports, observed staff to resident interactions as well as the provision of care to residents and services within the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that the areas in which drugs were stored were kept locked at all times, when not in use.

A RPN found that a door to a medication room was propped open and a resident was able to access the contents of the room. The resident was able to enter the medication room when the door failed to close properly when the registered staff member left the room. RPN #111 indicated that the resident had historically made attempts to enter the medication room and that they did not ensure the door had closed fully when they left the room.

The DOC indicated that the home's requirement was to ensure the medication room doors were kept secured due to a risk to residents, if they were able to enter the room unsupervised.

Sources: Progress Notes; Witness Incident Report; "Medication Management System - Drug Storage" policy; interviews with RPN #111 and other staff. [s. 130. 1.]

2. On December 10, 2020, Inspector #759 noted a medication room door was left open while no staff were immediately present. During this time, the RPN was noted to be assisting residents out of the dining room and assisted a resident to the bathroom.

The Inspector approached RPN #117, who indicated that they had forgotten to close the door, when they retrieved an item for a resident.

Sources: Observations made on December 10, 2020; "Medication Management System - Drug Storage" policy; interviews with RPN #117 and other staff. [s. 130. 1.]

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 any area where drugs are stored is kept locked at all times, when not in use, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's prescribed drug was administered to the resident in accordance with the directions for use specified by the prescriber.

A resident was prescribed a drug, but was able to access more of that drug than what was prescribed due to the medication room door being left open, please see finding #001 for details. The resident was noted to have a change in status.

The DOC indicated that only the prescribed amount of the drug should have been taken by the resident.

Sources: Progress Notes, Witness Incident Report, Meeting Notes with an RPN, interviews with the DOC and other staff. [s. 131. (2)]

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 a resident receives their prescribed amount of drug in accordance with directions by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

The Inspector conducted a tour of the home and noted on three resident home areas; two shower room doors left open and unattended as well as one tub room door left open and unattended.

In an interview with a RPN, they identified that the door to the tub room should be closed when not being monitored by staff. During a separate interview, the Co-DOC indicated that staff may have been getting a resident ready to be showered, however, the door should have been closed until they were present.

Sources: Inspector observations, interviews with the Co-DOC and other staff. [s. 9. (1) 2.]

Issued on this 23rd day of December, 2020

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

Original report signed by the inspector.