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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Apr 14, 2021	2021_669642_0010	025854-20, 002448-21	Critical Incident System

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

AMY GEAUVREAU (642), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 22-26, 2021.

The following intakes were inspected during this inspection:

One Critical Incident System (CIS) report was submitted to the Director regarding alleged concerns about a resident's actions towards another resident.

One CIS report was submitted to the Director regarding alleged concerns of neglect from a staff member towards a resident.

A concurrent Complaint Inspection #2021_669642_0009; a Follow-Up Inspection #2021_669642_0008; and a Director Order Follow-Up Inspection #2021_669642_0007 were conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Co-Director of Care/Infection Prevention Program Lead, Registered Dietitian (RD), Housekeeping staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, and internal investigation files, and reviewed relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 WN(s)**
- **0 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. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had their desired bedtime and rest routines supported to promote comfort, rest and sleep.

A Critical Incident (CI) report was submitted to the Director, related to allegations of neglect. According to the CI report, staff members were assisting a resident and heard another resident calling from their room. Upon entering this resident's room, the resident indicated that a staff member had not returned and that they did not receive their required assistance.

The Inspector reviewed the home's internal investigation notes, which identified this resident had waited for a period of time to be assisted to bed.

The Inspector interviewed the Director of Care who indicated that staff should have provided care to the resident, or informed another staff member. Upon investigation, it was determined that the staff member did not communicate the needs of the resident to other staff, which resulted in the resident having to wait to be assisted to bed.

Sources: CIS report, internal investigation documents, resident’s electronic progress notes, interview with DOC and other staff. [s. 41.]

Issued on this 20th day of April, 2021

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

Original report signed by the inspector.