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

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Original Public Report

Report Issue Date July 22, 2022
Inspection Number 2022_1324_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Barrie Long Term Care Centre Inc.

Long-Term Care Home and City
Roberta Place, Barrie

Lead Inspector
Ryan Goodmurphy (638)

Additional Inspector(s)
Chad Camps (609), Steven Naccarato (744)

Inspector Digital Signature
Steven C Naccarato
Digitally signed by Steven C Naccarato
Date: 2022.08.04 13:30:52 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 30 – June 3, 2022.

The following intake(s) were inspected:

- One intake related to a complaint form which alleged staff to resident verbal and emotional abuse;
- One intake related to alleged staff to resident improper care;
- Two intakes related to staff to resident abuse;
- One intake related to a complaint regarding meal services and alleged abuse; and
- One intake related to a complaint regarding resident care concerns.

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION – PLAN OF CARE

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

Non-compliance with: LTCHA, 2007 s. 6 (10)(c)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

Rationale and Summary
A complaint was submitted to the Director regarding the use of a specific intervention for a resident, which was indicated in their plan of care.

In several interviews with staff, they stated that the resident refused the intervention on many occasions.

The plan of care had not been revised to reflect the ineffectiveness of the care, which was low risk to the resident.

Sources: Complainant interview; review of a resident's health records; and interviews with a RPN (Registered Practical Nurse) and other staff. [744]

WRITTEN NOTIFICATION – POLICY TO PROMOTE ZERO TOLERANCE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 20 (1)

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
The Director of Care (DOC) was made aware of an allegation of staff to resident abuse, involving multiple residents. The home's abuse policy directed staff to ensure immediate support or assistance was provided to the residents who have been abused or neglected, or allegedly abused or neglected. The policy further directed staff to assess resident condition, evaluating the safety, emotional and physical wellbeing of the resident.

One resident was not included in the investigation regarding the allegation of abuse and their health care records did not have any assessments or notations regarding the resident condition after the allegation had been made.

Sources: A written statement by the PSW; The CIS (Critical Incident System) report; Home's policy titled "LTC Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised February 15, 2022; and interviews with the DOC and other staff. [638]

WRITTEN NOTIFICATION – NOTIFICATION REGARDING INCIDENTS

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

Non-compliance with: O. Reg. 79/10 s. 97 (1) (b)

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Rationale and Summary
The DOC was made aware of allegations of abuse towards multiple residents. Not all SDMs were notified within 12 hours.

Sources: A PSW's written statement; investigation interview notes with a PSW; written record placing a PSW on leave; email correspondence between the DOC and a PSW; Policy titled "LTC Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised February 15, 2022; interviews with the DOC and other staff. [638]

WRITTEN NOTIFICATION – REPORTS REGARDING CRITICAL INCIDENTS

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 107 (4) 2. i.

The licensee has failed to ensure that a licensee who is required to inform the Director of an incident shall make a report in writing to the Director setting out names of any residents involved in the incident.

Rationale and Summary
The Director of Care (DOC) was made aware of an allegation of staff to resident abuse, involving multiple residents. The CI (Critical Incident) report submitted to the Director did not identify a resident as part of the incident.

The DOC identified that this resident must have been missed during the initial review of the written allegation.

Sources: A written statement from a PSW; The CI report; and interviews with the DOC and other staff. [638]

COMPLIANCE ORDER [CO#001] – DUTY TO PROTECT

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 *s. 19 (1) and FLTCA, 2021 s. 24 (1)*

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with LTCHA, 2007 s. 19. (1) and FLTCA, 2021, s. 24. (1)

The licensee shall:
a) Ensure that all new staff complete, in its entirety, zero-tolerance of abuse and neglect of residents training, before performing their responsibilities, by developing and implementing an auditing process. A copy of the audits must be kept in the home that is accurate and complete for at least one month post compliance due date to support sustainability;

b) Conduct a documented review of all zero-tolerance of abuse and neglect of residents training for all staff to ensure that the training was completed, including but not limited to any tests, quizzes, and signed declarations of wrong-doing. Implement appropriate corrective action to address any concerns identified during the review.

Grounds

1. Non-compliance with: LTCHA, 2007 s. 19. (1)

The licensee has failed to ensure that three residents were protected from abuse by a PSW.

The Long-Term Care Homes Act (LTCHA), 2007, defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain. The LTCHA defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary
Three residents were emotionally distressed by a PSW's care, which caused the residents to fear the PSW.

Furthermore, despite the home's policy which required staff complete zero-tolerance of abuse and neglect of residents training on orientation, the PSW did not complete the training prior to providing resident care.

There was moderate harm to the three residents who were emotionally distressed by the incident.

Sources: The home's policy titled "LTC Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last reviewed February 15, 2022; a PSW's Human Resource (HR) file and training logs; and interviews with the DOC, Acting Administrator, a resident; a PSW; a RN; the home's internal investigation; and the Critical Incident report. [609]

2. Non-compliance with: FLTCA, 2021 s. 24. (1)

The licensee has failed to ensure that a resident was protected from abuse by a PSW.

The Fixing Long-Term Care Act (FLTCA), 2021, defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary
A PSW provided care to a resident in a manner that was uncomfortable for the resident. When the resident communicated their discomfort, the PSW dismissed the resident and began to display aggressive behaviours. This incident caused the resident to become emotionally distressed.

There was moderate harm to the resident who was emotionally distressed by the incident.

Sources: the home's internal investigation; the CI report; the PSW's Human Resource file; interviews with the resident; PSWs; and the DOC. [609]

3. Non-compliance with: FLTCA, 2021 s. 24. (1)

The licensee has failed to protect residents in the home from abuse.

Rationale and Summary
A PSW, who was sent off work pending the outcome of an abuse investigation, returned to work despite the home's intention for the PSW to remain off work.

The DOC verified that they did not call the PSW with the direction not to return to work and acknowledged that their lack of awareness that the PSW was in the home and had provided direct care to the resident, could have resulted in harm.

Sources: Interviews with the resident; the PSW; a RPN; the DOC; and the Acting Administrator. [609]

This order must be complied with by September 9, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP #001]

COMPLIANCE ORDER [CO#002] REPORTING CERTAIN MATTERS TO DIRECTOR

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 24 (1) and FLTCA, 2021 s. 28 (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with LTCHA, 2007 s. 24. (1) and FLTCA, 2021, s. 28. (1)

The licensee shall:
a) Re-train two PSWs and one PSA (Personal Support Assistant) on the home's processes related to prevention of abuse and neglect including reporting requirements when abuse, neglect or improper care is witnessed, suspected or alleged;
b) Re-train the DOC on requirements for reporting to the Director, including but not limited to the timeframes for reporting; and
c) Maintain a record of the training and everyone who has completed including dates of completion.

Grounds

1. Non-compliance with: FLTCA, 2021 s. 28 (1)

The licensee has failed to ensure that allegations of improper care for three residents were immediately reported to the Director.

Rationale and Summary
A Personal Support Assistant alleged that a PSW provided improper care for two residents, as well as attempted an unsafe transfer of one resident. These allegations were not immediately reported to the home's management.

The DOC indicated that allegations of improper care that were witnessed or suspected by staff were to be immediately reported to their supervisor.

There was low risk to the residents for not immediately reporting the allegations of improper care to the Director.

Sources: The CI report; internal investigation notes; Policy titled "LTC Abuse- Zero- Tolerance Policy for resident Abuse and Neglect" last revised February 15, 2022; and an interview with the DOC. [744]

2. Non-compliance with: LTCHA, 2007 s. 24 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

Rationale and Summary
a) The DOC was made aware of an allegation of staff to resident abuse. It was identified that the PSW failed to immediately report incidents of suspected abuse.

The PSW's actions placed the residents at risk of further abuse by not immediately reporting their concerns at the time of the incidents.

b) During an interview with a PSW, they alleged that another staff member was abusive towards residents. The PSW failed to immediately report suspected abuse at the time it was identified.

The PSW's actions placed residents at risk of further abuse by not immediately reporting their concerns at the time of the incidents.

c) The DOC identified that multiple PSWs alleged staff to resident abuse involving another PSW. These allegations of abuse were not immediately reported to the Director.

Sources: A PSW's written warning; A PSW's written statement; investigation interview notes with a PSW; written record placing a PSW on leave; email correspondence between DOC and a PSW; Policy titled "LTC Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised February 15, 2022; interviews with the DOC and other staff. [638]

This order must be complied with by September 2, 2022

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty [AMP #001]
Related to Compliance Order [CO #001]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **[$5500.00],** to be paid within 30 days of from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- Order #001 of inspection #2021_864627_0024 LTCHA, 2007 s. 19. (1); and
- Order #001 of inspection #2020_746692_0013 LTCHA, 2007 s. 19. (1).

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.

- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.