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 District**
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

# Original Public Report

| | |
|---|---|
| **Report Issue Date:** August 30, 2023 | |
| **Inspection Number:** 2023-1324-0006 | |
| **Inspection Type:**<br>Critical Incident | |
| **Licensee:** Barrie Long Term Care Centre Inc. | |
| **Long Term Care Home and City:** Roberta Place, Barrie | |
| **Lead Inspector**<br>Craig Michie (000690) | **Inspector Digital Signature**<br>Craig R Michie Digitally signed by Craig R Michie Date: 2023.09.06 13:53:41 -04'00' |
| **Additional Inspector(s)**<br>Kim Byberg (729) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15-18, and 21, 2023.

The following intake(s) were inspected in this Critical Incident (CI) inspection:
- Intake: #00018729, related to an allegation of abuse towards a resident.
- Intake: #00088929, related to an injury which resulted in transfer to hospital.
- Intake: #00091715, related to fall prevention and management.

The following intake(s) were completed in this Critical Incident (CI) inspection:
- Intake: #00087667, and Intake: #00087729, related to fall prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Fall prevention and management

**NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, a Head Injury Routine (HIR) assessment was conducted.

**Rationale and Summary**
The resident had a fall and an HIR was initiated.

HIR monitoring includes an assessment of a resident's vital signs, level of consciousness, pupil reaction and size, resident responses, and movement of extremities.

These assessments were to be completed 15 times within a 24 hour timeframe.

The assessment of the resident's pupil size was not documented 10 times. When the resident was sleeping, HIR assessments were not done on four occasions and were missed on two other occasions. The resident was later transferred to hospital.

The Director of Care (DOC) stated that all aspects of the assessment should have been completed, and that the resident should have been woken to ensure that they were alert and awake.

By not completing HIR assessments as required, there was a risk of a head injury not being detected.

**Sources:**
The resident's clinical records, LTC Emergency Care - Head Injury Routine policy, interview with DOC and other staff members.
[000690]