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

Public Report

Report Issue Date: January 15, 2025
Inspection Number: 2024-1324-0004
Inspection Type: Complaint Critical Incident
Licensee: Barrie Long Term Care Centre Inc.
Long Term Care Home and City: Roberta Place, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7-10 and 14-15, 2025.

The following intake(s) were inspected:

- Intake: #00129307, related to prevention of abuse and neglect, and responsive behaviours.
- Intake: #00131540, related to prevention of abuse and neglect, and responsive behaviours.
- Intake: #00129627, a complaint related to prevention of abuse and neglect.
- Intake: #00130700, a compliant related to prevention of abuse and neglect, pain management and food, nutrition and hydration.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from physical abuse from another resident.

"Physical abuse" means, subject to subsection (2), the use of physical force by a resident that causes physical injury to another resident.

A resident wandered into another resident's room and staff did not redirect them. A physical altercation occurred between the residents and the resident who's room the other resident wandered into received a laceration to their head.

Sources: Critical Incident Report, the residents care plan, the resident's skin and wound assessment, incident report, interviews with RPN.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that an incident of alleged abuse of a resident by anyone was immediately investigated.

(A) A resident reported alleged abuse allegations to three RN's. The home did not conduct an internal investigation into this incident.

Sources: Residents Progress Notes, Interview with DOC.

(B) A resident reported alleged abuse allegations to the Administrator. The home did not conduct an internal investigation into the reported concerns.

Sources: Residents Progress Notes, Interview with Administrator.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that the residents wandering interventions were followed by staff. A physical altercation took place when staff failed to redirect resident from entering a co-resident's room.

Sources: Observation, the residents care plan and progress notes, interviews with a RN and a RPN.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that a residents monitoring through the home's Dementia Observation System (DOS) was initiated promptly and fully documented. The resident was involved in an altercation with a co-resident, but the DOS data collection did not begin until five days later and remained incomplete.

Sources: The residents DOS data collection sheet, interview with DOC.