

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: June 5, 2025

Inspection Number: 2025-1324-0002

Inspection Type:

Critical Incident
Follow up

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): May 28-30, 2025 and June 2-5, 2025

The following intake(s) were inspected:

- Intake #00141474, CI #2839-000011-25 - related to an outbreak.
- Intake #00142105, Follow-up #1 - CO #001 / 2025-1324-0001, O. Reg. 246/22 - s. 59 (b) Altercations and other interactions between residents.
- Intake #00142387, CI# 2839-000013-25 - related to resident to resident abuse.
- Intake #00142566, CI #2839-000014-25 - related to an outbreak.
- Intake #00143662, CI #2839-000015-25 - related to an outbreak.
- Intake #00143975, CI #2839-000017-25 - related to an outbreak.
- Intake #00145914, CI# 2839-000020-25 - related to a fall of a resident resulting in injury.
- Intake #00146188, CI #2839-000021-25 - related to an outbreak.

Previously Issued Compliance Order(s)

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The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1324-0001 related to O. Reg. 246/22, s. 59 (b)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the falls prevention and management program provided for the use of equipment, supplies, devices and assistive aids for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, includes the use of

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devices and provides strategies to monitor residents, and must be complied with. The home's policy stated Personal Support Workers were required to implement preventative measures as per the plan of care to prevent falls and/or injury.

A resident required falls prevention interventions. The resident was observed without these interventions in place.

Source: Observations, Falls Prevention and Management Program Policy version 11 (revised date: August 23, 2024), care plan, documentation survey report, interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

a) In accordance with Additional Requirement 9.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that additional precautions were followed in the IPAC program, specifically (a) the use of evidence-based practices related to potential contact transmission and required precautions.

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A staff member did not wear a gown when assisting a resident, who was on contact precautions, with personal care.

Sources: Observation, interviews with staff and IPAC Lead

b) In accordance with Additional Requirement 9.1 (b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that staff followed Routine Practices with respect to performing hand hygiene according to the four moments of hand hygiene.

A staff member did not perform hand hygiene upon exiting and re-entering a resident's room.

Sources: Inspector observations, interviews with staff and IPAC Lead