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
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Public Report

Report Issue Date: December 11, 2025

Inspection Number: 2025-1324-0005

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): November 25-27, 2025 and December 1-3, 9, 11, 2025.
The inspection occurred offsite on the following date(s): December 5, 2025.

The following intake(s) were inspected:
-Intake: #00157679: related to fall prevention and management.
-Intake: #00159448, and Intake: #00163051: related to prevention of abuse and neglect.
-Intake: #00161344: related to responsive behaviour management.
-Intake: #00163172: related to a complaint related to an allegation of resident abuse

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

Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management

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).

A resident was at risk for falls. The home implemented fall prevention interventions; however, the intervention was not functioning to alert staff that the resident was mobilizing. The resident subsequently had a fall and sustained an injury that required them to be transferred to the hospital for treatment.

Sources: Progress notes, post fall assessment, restorative care referral, Fall Prevention Program policy, interview with PSW's, and the co-Director of Care.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

A registered staff identified a laceration on a resident. An assessment using a clinically appropriate assessment instrument specifically designed for skin and wound care or interventions to treat the laceration were not completed.

Sources: review of a residents progress notes, electronic medication administration record (eMAR), skin issue assessment and interview with the co-Director of Care.

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

A resident had a fall resulting in an injury. After the initial and secondary doses of an analgesic were ineffective, the registered staff did not call the physician to re-evaluate their pain management regime or a trial of other pain management strategies.

Sources: review of resident's progress notes, review of eMAR, PAINAD assessments, and interviews with the DOC and a Registered Nurse (RN).

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.

Two residents had a history of resident to resident altercations towards one another. Staff were to monitor the location of each resident, intervene, and redirect each resident to prevent altercations. The home did not complete reassessments of each residents' behaviour, trial or implement any new interventions after altercations occurred to mitigate further risk and harm until an alleged altercation occurred that resulted in a resident sustaining an injury.

Sources: review of progress notes for each resident, plan of care, external referrals, circle of care meeting minutes, and interview with co-DOC, and an RN.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

A resident had a history of verbal and physical altercations towards other residents. The home identified specific residents and environmental stimulants that would trigger negative responses from the resident that put other residents at risk of harm. On a specific day, the resident had an altercation with a co-resident. The home did not react and implement interventions, and as a result injuries were sustained.

Sources: progress notes, incident reports, behaviour support consultation notes, observations during the inspection, and interview with the co-DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident required an analgesic for pain. The registered nursing staff administered medication that exceeded the amount of medication that was prescribed by the physician.

Sources: review of a residents progress notes, physician orders, electronic medication administration record (eMAR), interview with the DOC.