Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 16, 2014	2014_299559_0001	T-587-13	Critical Incident System

Licensee/Titulaire de permis

BARRIE LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

Long-Term Care Home/Foyer de soins de longue durée

ROBERTA PLACE
503 ESSA ROAD, BARRIE, ON, L4N-9E4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ANN HENDERSON (559)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 13, 14, 15, 2014

During the course of the inspection, the inspector(s) spoke with Director of Care, (Former) Co-Director of Care, Staff Educator #2, Resident and Family Services, Registered Practical Nurses,Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed relevant home's policies related to abuse and neglect and clinical records.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right not be neglected by licensee or staff is fully respected and promoted.

An interview with an identified personal support worker (PSW) revealed that on an identified date, he/she had been asked to come in early due to staff shortages on the night shift. The PSW indicated that he/she arrived at 04:00h on an identified home area and found residents #001,#002 and #004 with call bells ringing. The PSW revealed that all three residents required immediate care. The PSW indicated that after he/she had attended to all three residents, he/she proceeded to find the staff assigned to this home area. The PSW revealed that at 04:20h he/she found the night PSW lying on a couch asleep with a cover on and the Registered Practical Nurse (RPN) in the TV lounge with the door closed sound asleep with a blanket on. The PSW reported what had occurred to the charge nurse who reported the incident to the co-DOC, who confirmed that neglect was suspected. The co-DOC revealed during an interview that the incident was not immediately reported to the Director, however, did confirm that an investigation was commenced immediately and the incident of neglect was reported to the Director three days later. [s. 3. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's right not be neglected by licensee or staff is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that neglect of a resident by the licensee or staff resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director s.24(1)2

Staff interviews and clinical record review revealed that on an identified date approximately at 06:00h a PSW reported to the night registered practical nurse and the charge nurse that at 04:00h he/she had found resident #001, #002, #004 with call bells ringing requiring staff assistance on an identified home area. The PSW reported that he/she had attended to all three residents and then indicated that the two staff members assigned to this home area were found asleep at 04:20h. The charge nurse reported the incident to the co-DOC, who confirmed that neglect was suspected. The co-DOC revealed during an interview that the incident was not immediately reported to the Director, however, did confirm that an investigation was commenced immediately and the incident of neglect was reported to the Director three days later. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that neglect of a resident by the licensee or staff resulted in harm or risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 17th day of January, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Ann Henderson