Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 8, 2019	2019_782736_0020	009799-19	Critical Incident System

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 711 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

AMANDA BELANGER (736)

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): July 30- August 1, 2019.

The following intake was inspected during this Critical Incident Inspection:

-one log related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (Acting DOC), Care Service Coordinator, Registered Nurse (s) (RNs), Registered Practical Nurse(s) (RPNs), Personal Support Worker(s) (PSWs), and residents.

During the course of the inspection, the Inspector(s) conducted a daily tour of the resident care areas, observed the provision of care, staff to resident interactions, reviewed relevant health records, and relevant policies and procedures.

A Complaint Inspection, #2019_782736_0019, was conducted concurrently with this CIS Inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out a description of the incident, including the events leading up to the incident.

A Critical Incident (CI) report was submitted to the Director for a fall of resident #002 that resulted in an injury with significant change in status. The CI report indicated that the resident had been found at a specified location by a Personal Support Worker (PSW).

Twelve days after the incident, the CI report was amended to include the events leading up to the incident.

A review of the policy titled "Resident Rights, Care and Services- Reporting and Complaints- Critical Incident Reporting" last revised March 15, 2019, indicated that the home was to ensure that within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out a description of the incident, and the events leading up to the incident.

In an interview with the Administrator, they indicated to Inspector #736 that the Administrator, Director of Care, or Nurse Managers, were responsible to submit and update the CI reports as required. Together, the Administrator and Inspector reviewed the CI report that was submitted to the Director for resident #002 sustaining a fall with significant injury. The Administrator indicated that the events leading up to the fall were not provided to the Director within 10 days, and should have been. [s. 107. (4) 1.]

Issued on this 9th day of August, 2019

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

Original report signed by the inspector.