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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

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_0019	013213-19	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): July 30- August 1, 2019.

The following intake was inspected during the course of this Complaint Inspection:

-one log related to a complaint submitted to the Director regarding an allegation of sexual abuse.

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

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

A Critical Incident System Inspection, #2019_782736_0020, was conducted concurrently with this Complaint Inspection.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that results of every investigation related to every alleged, suspected or witnessed incident of the abuse of a resident by anyone, or that is reported to the licensee, was reported to the Director.

A complaint was submitted to the Director regarding an allegation of sexual abuse of a resident within the home. The complainant described what they had observed in resident #001's room, and indicated that there was a concern of potential sexual abuse towards resident #001. The complainant further indicated that the home's Director of Care (DOC) was aware of the concern, and had completed an investigation.

Inspector #736 reviewed the home's internal investigation binder and noted a concern from the complainant to the Administrator, specific to resident #001. The home's internal investigation notes indicated in the initial description of the concern from the complainant and indicated that the home's DOC at the time completed an investigation.

The Inspector was unable to locate a report submitted to the Director related to the investigation of the suspicion of the sexual abuse of resident #001.

In an interview with the Administrator, they indicated to Inspector #736, that they were aware of the complaint from resident #001's family member, and that the previous DOC had completed an investigation. The Administrator confirmed that the family of resident #001 had been concerned at the time. The Administrator indicated that the home had investigated the concerns. [s. 23. (2)]

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.