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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965
northdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 15 , 2022
Inspection Number: 2022-1324-0003
Inspection Type: District Initiated Complaint Critical Incident System
Licensee: Barrie Long Term Care Centre Inc.
Long Term Care Home and City: Roberta Place, Barrie

Lead Inspector	**Inspector Digital Signature**
Amanda Belanger (736)	Amanda Belanger Digitally signed by Amanda Belanger Date: 2022.12.21 14:26:21 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 14-18, and November 21-23, 2022.

The following intake(s) were inspected:

- One intake related to an unexpected death of a resident;
- One intake related to resident to resident responsive behaviours;
- One intake related to the fall of a resident with a change in health status;
- One intake related to an allegation of staff to resident physical abuse; and,
- One intake related to a SAO initiated inspection regarding care and services related to low water pressure.

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

Falls Prevention and Management
Prevention of Abuse and Neglect
Responsive Behaviours
Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by a Personal Support Worker (PSW).

Summary and Rationale
Ontario Regulation (O.Reg.) 246/22, defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

The resident and the PSW had an altercation, that resulted in the resident sustaining an injury from the actions of the PSW.

The Acting Administrator confirmed that the incident met the definition of staff to resident physical abuse, and the resident was not protected from abuse by the staff member.

There was moderate harm to the resident, and was required to have additional monitoring.

Sources: Critical Incident (CI); the resident's progress notes; internal investigation; Licensee Policy titled Zero Tolerance Policy for Resident Abuse and Neglect, revised July 2022; interview with Acting Administrator, and other staff.

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WRITTEN NOTIFICATION: Abuse Policy

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Summary and Rationale
The licensee's policy titled "LTC Abuse-Zero Tolerance for Resident Abuse and Neglect", last revised July 2022, directed the most Senior Administrative Personnel to send a staff member accused of resident abuse home, pending the outcome of the abuse investigation.

The Registered Nurse (RN) made the Co-Director of Care (Co-DOC) aware of an allegation of staff to resident physical abuse. The Co-DOC did not give the direction to have the PSW removed from resident care until the investigation was completed.

In an interview with the Director of Care (DOC), they indicated that the staff member was not removed immediately after the allegation of abuse, and as per the home's policy, they should have been.

There was actual risk of harm to residents, the PSW had been witnessed to abuse the resident, and continued to interact with other residents during the duration of their shift.

Sources: CI; internal investigation notes; licensee policy titled "LTC Abuse-Zero Tolerance for Resident Abuse and Neglect", PSW time sheet; interview with DOC and other staff.

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WRITTEN NOTIFICATION: Reporting to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that the allegation of staff to resident physical abuse, involving a resident was immediately reported to the Director.

Summary and Rationale
It was alleged that the PSW had physically abused a resident. The RN informed the Co-DOC of the incident immediately after the resident was attended to. The Co-DOC did not immediately report the allegation of staff to resident abuse to the Director.

In an interview with the Acting Administrator, they indicated that the allegation of staff to resident abuse should have been immediately reported to the Director, using the After Hours line.

There was minimal risk of harm by the allegation of staff to resident abuse not being immediately reported to the Director.

Sources: CI; internal investigation notes; licensee policy titled Zero Tolerance for Resident Abuse and Neglect; interview with Acting Administrator, and other staff.

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WRITTEN NOTIFICATION: Reports to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (4) 4.

The licensee has failed to ensure that when the licensee reports an unexpected death, the written report includes the immediate and long term actions to prevent recurrence within 10 days.

Summary and Rationale
A CI was submitted to the Director related to the unexpected death of the resident. At the time of the submission, the immediate and long-term actions to prevent recurrence both indicated that they were pending further review.

The CI was not amended within 10 days to include the outcome of the investigation.

In an interview with the Acting Administrator, they indicated that the CI should have been amended within 10 with any further information that was gathered.

Sources: CI; licensee policy titled LTC Mandatory Reporting to MOLTC of Critical Incidents, revised February 2022; interview with Acting Administrator.

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WRITTEN NOTIFICATION: Notification of Substitute Decision Maker

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (1) (a)

The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was made aware immediately of an alleged, suspected or witnessed incident of abuse that resulted in a physical injury to the resident.

Summary and Rationale
The PSW was witnessed to physically abuse the resident, which resulted in an injury.

In an interview with the DOC, they indicated that the SDM was not immediately notified of the allegation of staff to resident abuse, and should have been, as there was an injury.

There was moderate risk of harm to the resident, as the SDM was not given the opportunity to be with the resident after the allegation of staff to resident abuse, to provide emotional support.

Sources: The resident's progress notes; licensee policy titled "LTC Abuse-Zero Tolerance for Resident Abuse and Neglect"; interview with Acting Administrator, and other staff.

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WRITTEN NOTIFICATION: Minister's Directive

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the Minister's Directive, related to universal masking of staff and visitors was followed.

Summary and Rationale
Minister's Directive: COVID-19, effective August 30, 2022, directed the homes to ensure that all staff and visitors wore a well-fitted medical mask for the entire duration of their shift/visit, while indoors, regardless of their COVID-19 vaccination status.

The Inspector observed a visitors without their masks covering their mouth and nose while in common areas of the home. There was no redirection provided by staff who were present or in the area.

In an interview with the Infection Prevention and Control (IPAC) lead, they indicated that staff were to

provide redirection to visitors if there were breaches in the masking protocol within the home, and that maskless visits were only to take place in a resident's room, with no one else, except the resident and visitor present.

There was low risk to the residents, as visitors are screened and tested upon entry to the home.

Sources: Minister's Directive, Inspector observations; interviews with the IPAC lead, and other staff.

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