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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: November 8, 2024

Inspection Number: 2024-1324-0003

Inspection Type:
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): October 30-31, and November 1, 4, 2024.

The following intake(s) were inspected:

- Intake #00128230, CI #2839-000060-24 - related to resident to resident abuse.
- Intake #00128746, CI #2839-000061-24 - related to an infectious disease outbreak.

The following intakes were completed in this inspection:

- Intake #00123363, CI #2839-000043-24 - related to an infectious disease outbreak.
- Intake #00125034, CI #2839-000047-24 - related to an infectious disease outbreak.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse by another resident.

According to O. Reg 246/22 s. 2 (1), sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary
An incident occurred where a resident was inappropriately touched by another resident.

The Director of Care (DOC) acknowledged that the resident who was inappropriately touched was not able to make an informed decision to give consent to the touching.

Sources: CIS Report, investigation note, interview with DOC.

WRITTEN NOTIFICATION: Licensee must investigate, respond,

and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

The licensee has failed to ensure that a witnessed incident of resident-to-resident abuse was immediately investigated and that appropriate actions were taken in response to this incident.

Rationale and Summary
The home's policy provided direction on what to do after an abuse incident.

Staff observed an incident between two residents.

The Director of Care (DOC) indicated that the home did not complete the steps outlined in the home's policy to investigate and respond to such incidents.

When the licensee failed to ensure that the incident was immediately investigated and that appropriate actions were taken, a second incident of similar nature took

place.

Sources: Sexual expression and intimacy policy version 1 (last review date: September 9, 2024), resident progress notes, interview with DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

a) The licensee has failed to ensure that a witnessed incident of abuse was immediately reported to the Director.

Rationale and Summary
An incident of inappropriate touching occurred and it was not reported to the Director until the following day.

The Director of Care (DOC) acknowledged that the home should have reported the incident immediately.

When the licensee failed to ensure that the incident was reported immediately to the Director, it may have delayed the Director from responding to the incident.

Sources: CIS Report, interviews with staff.

b) The licensee has failed to ensure that a witnessed incident of abuse was immediately reported to the Director.

Rationale and Summary
Two incidents occurred where staff observed two residents share an intimate moment.

The Director of Care (DOC) acknowledged that the home did not report the incidents to the Director.

When the licensee failed to ensure that the incidents were reported to the Director, the Director would not have known about the incidents and could not have responded to the incidents in a timely manner.

Sources: Resident's progress notes, interview with DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement a standard issued by the Director with respect

to infection prevention and control.

The licensee failed to ensure that Additional Precautions were followed in the infection prevention and control (IPAC) program in accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes April 2022" (IPAC Standard). Specifically, the licensee did not ensure staff selected and applied appropriate personal protective equipment (PPE) when staff were interacting with a resident on contact precautions as required by Additional Requirement 9.1 (f) under the IPAC Standard.

Rationale and Summary
A resident was on contact precautions. They had contact precautions signage posted outside their room which indicated a long sleeve gown and gloves were to be worn for direct care.

Multiple staff provided direct care to the resident without donning gowns.

The IPAC lead stated that when providing direct care for the resident, staff were expected to wear a gown and gloves.

When staff did not wear the appropriate PPE when providing direct care for a resident on contact precautions, there was risk of transmitting an infectious disease.

Sources: Resident's clinical documents; Observation; Interviews with staff.