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

Public Report

Report Issue Date: March 10, 2025

Inspection Number: 2025-1324-0001

Inspection Type:
Complaint
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): March 3-7, 10, 2025
The inspection occurred offsite on the following date(s): March 6, 2025

The following intake(s) were inspected:

- Intake #00135441, CI #2839-000073-24 - related to the neglect of a resident.
- Intake #00136101, CI#2839-000001-25 - related to the improper/incompetent treatment or care/abuse of resident.
- Intake #00136888, CI#2839-000002-25 - related to resident to resident abuse.
- Intake #00139920, CI #2839-000007-25 - related to the improper transfer of a resident.
- Intake #00140303, CI #2839-000009-25 -related to the improper transfer of a resident.
- Intake #00140242 - complaint regarding wound care of a resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Continence Care
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 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.

The licensee has failed to ensure that the neglect of a resident was immediately reported to the Director. Pursuant to s.154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

A Personal Support Worker (PSW) suspected neglect of a resident during morning care. The PSW did not report the finding to the home until three days later.

Sources: Critical Incident Report, home's internal investigation, interviews with the Director Of Care (DOC).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when they assisted a resident with care. As a result, the resident was injured.

Sources: Resident's clinical records; Homes investigation notes; Interviews with staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a resident was assessed using a clinically appropriate assessment instrument when there was evidence of injury to their head. In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the Falls Prevention and Management Program policy of the long-term care home is to be complied with.

Specifically, registered staff did not comply with the licensee's Head Injury Routine (HIR) Policy and ensure a HIR was initiated for a resident when they were identified to have an injury of unidentified origin on their face.

Sources: Interviews with multiple registered staff, resident's clinical records, and LTC Emergency Care - Head Injury Routine Policy (Last revised 12/03/2023)

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee failed to ensure that a resident had sufficient changes to remain clean, dry and comfortable.

Staff did not follow a resident's toileting routine as set out in their care plan. The delay in providing continence care for the resident led to a worsening of the resident's wounds.

Sources: Critical Incident Report, Home's internal investigation, Resident's clinical records, home's investigation notes, and interviews with staff.

COMPLIANCE ORDER CO #001 Altercations and other interactions between residents

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:
1) Identification of intervention(s) to minimize the risk of altercations between residents of the unit resident #003 resides on, in relation to resident #003's known behaviours towards co-residents.
A) Ensure the identification process involves consultation with the interdisciplinary team. Maintain a record of the consultation, including the person(s) involved, the contents of discussion, and the date the consultation(s) occurred.
2) Following identification of intervention(s), PSW and nursing staff of the unit resident #003 resides on shall be trained on the implementation of the intervention(s). A record is to be maintained of the education, including the content, dates it was provided, persons who attended, as well as who provided the education.
3) A daily audit will be conducted for implementation of the intervention(s) for a full week period. A record will be maintained of:
A) Who completed the audit, the dates it was completed, the results, and any

deficiencies that were identified.
B) If deficiencies are identified, maintain a record of the dates they were discovered, as well as any remedial actions, and the dates they were taken.

Grounds

The licensee failed to ensure interventions were identified and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #003 had a history of physical and verbal expressions towards other residents.

A subsequent incident occurred. Staff noted resident #003's care plan did not include proactive interventions to minimize the risk of altercations between resident #003 and other residents.

As a result, multiple residents in the unit were at increased risk of altercations and harm.

Sources: Resident clinical records, Interviews with staff, Critical Incident Reports.

This order must be complied with by May 30, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.