Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 18, 2021	2021_828744_0004	000511-21	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

STEVEN NACCARATO (744)

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): January 12-13, 2021.

The following intake was inspected upon during this Critical Incident System (CIS) Inspection:
-One intake submitted to the Director, related to a COVID-19 outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Care Services Coordinator, Activity Aide, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

The Inspector also conducted a daily tour of resident care areas, reviewed relevant health care records and observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to staff and resident cohorting as required by the direction of the Chief Medical Officer of Health in COVID-19 Directive #3 for Long-Term Care Homes (LTCH).

Directive #3, indicated that LTCHs must have a plan for and use, to the extent possible, staff and resident cohorting.

a) The Inspector identified resident rooms that were shared by both confirmed COVID-19 positive residents and residents not confirmed to have COVID-19. A Personal Support Worker (PSW) indicated that residents within these shared rooms would often come into close contact with each other.

b) Certain staff were providing care to both confirmed COVID-19 positive residents and residents not confirmed to have COVID-19. The Administrator indicated that cohorting of staff on all resident home areas, was not always possible.

Not cohorting staff and residents, placed other residents in the home at risk of disease transmission.

Sources: Inspector observations on January 12 and 13, 2021; Chief Medical Officer of Health Directive #3 for Long-Term Care Homes, effective December 7, 2020; and interviews with a PSW, the Administrator and other staff.

2) The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to isolation of residents as required by the direction of the Chief Medical Officer of Health in COVID-19 Directive #3 for Long-Term Care Homes.

Directive #3 indicated that once at least one resident has presented with new symptoms compatible with COVID-19, the LTCH should place the symptomatic resident in isolation under droplet and contact precautions.

All residents in the home were required to be in their room isolating under droplet and contact precautions at all times. Multiple residents were observed out of isolation, touching high-touch surfaces and coming in close contact with other residents. Some of these residents were identified as COVID-19 positive. A Registered Practical Nurse (RPN) indicated that they tried to keep residents isolated but some residents refused to stay in their rooms.

Residents not isolating placed other residents at risk for disease transmission.

Sources: Inspector observations on January 12 and 13, 2021; Chief Medical Officer of

Health Directive #3 for Long-Term Care Homes, effective December 7, 2020; and interviews with the RPN and other staff. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 19th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEVEN NACCARATO (744)
Inspection No. / No de l'inspection :	2021_828744_0004
Log No. / No de registre :	000511-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 18, 2021
Licensee / Titulaire de permis :	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Roberta Place 503 Essa Road, Barrie, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tricia Swartz

To Barrie Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall ensure:

All requirements specified by the Chief Medical Officer of Health (CMOH) in the latest version of Directive #3 for Long-Term Care Homes for COVID-19 are implemented in the home. Specifically, the licensee must ensure:

a) Cohorting of affected and unaffected residents and staff in the home to the extent possible; and
b) Isolation of residents required by the direction of the Chief Medical Officer of Health in Directive #3 for Long-Term Care Homes to the extent possible.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to staff and resident cohorting as required by the direction of the Chief Medical Officer of Health in COVID-19 Directive #3 for Long-Term Care Homes (LTCH).

Directive #3, indicated that LTCHs must have a plan for and use, to the extent possible, staff and resident cohorting.

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b) Certain staff were providing care to both confirmed COVID-19 positive residents and residents not confirmed to have COVID-19. The Administrator

indicated that cohorting of staff on all resident home areas, was not always possible.

Not cohorting staff and residents, placed other residents in the home at risk of disease transmission.

Sources: Inspector observations on January 12 and 13, 2021; Chief Medical Officer of Health Directive #3 for Long-Term Care Homes, effective December 7, 2020; and interviews with a PSW, the Administrator and other staff.

2) The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to isolation of residents as required by the direction of the Chief Medical Officer of Health in COVID-19 Directive #3 for Long-Term Care Homes.

Directive #3 indicated that once at least one resident has presented with new symptoms compatible with COVID-19, the LTCH should place the symptomatic resident in isolation under droplet and contact precautions.

All residents in the home were required to be in their room isolating under droplet and contact precautions at all times. Multiple residents were observed out of isolation, touching high-touch surfaces and coming in close contact with other residents. Some of these residents were identified as COVID-19 positive. A Registered Practical Nurse (RPN) indicated that they tried to keep residents isolated but some residents refused to stay in their rooms.

Residents not isolating placed other residents at risk for disease transmission.

Sources: Inspector observations on January 12 and 13, 2021; Chief Medical Officer of Health Directive #3 for Long-Term Care Homes, effective December 7, 2020; and interviews with the RPN and other staff. [s. 5.]

An order was made by taking the following factors into account:

Severity: Actual risk was identified in the home related to risk of disease transmission.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Scope: The scope of this non-compliance was widespread because of the number of identified concerns in all home areas, related to ensuring a safe environment for its residents.

Compliance History: 12 previous Compliance Orders (COs), 30 Voluntary Plans of Correction (VPCs) and 15 Written Notifications (WNs) were issued to the home related to different sub-sections of the legislation in the past 36 months. (744)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 25, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Steven Naccarato

Service Area Office /
Bureau régional de services : Sudbury Service Area Office