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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 14, 2019	2019_745690_0019	014371-19	Critical Incident System

Licensee/Titulaire de permis

Victoria Village Inc.
76 Ross Street BARRIE ON L4N 1G3

Long-Term Care Home/Foyer de soins de longue durée

Victoria Village Manor
78 Ross Street BARRIE ON L4N 1G3

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

TRACY MUCHMAKER (690)

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): August 7-8, 2019.

The following intake was completed during this inspection:
-One log that was submitted to the Director related to alleged staff to resident abuse.

A Follow up Inspection (2019_745690_0018) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Services (DONS), Assistant Director of Nursing Services (ADONS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident (CI) report was submitted to the Director for alleged staff to resident abuse. The CI report indicated that resident #001 reported that a staff member did not use an identified intervention during care, and that the staff member was abusive towards them. The resident had sustained an identified injury from the incident.

During an observation of resident #001's room, Inspector #690 identified a document that indicated that resident #001 was to be assisted with an Activity of Daily Living (ADL) with a specified level of assistance.

A review of resident #001's electronic care plan on Point Click Care (PCC) indicated that resident #001 was to have a different level of assistance for care at all times due to an identified responsive behaviour.

In an interview with Inspector #690, Personal Support Worker (PSW) #108 indicated that resident #001 previously required a specified level of assistance for activities of daily living (ADL), but after the allegation of abuse, the care level had changed. PSW #108 indicated that they would utilize the Kardex on PCC to find out what assistance a resident required with ADLs.

In an interview with Registered Practical Nurse (RPN) #107, they indicated that resident #001 previously required a specified level of assistance for activities of daily living (ADL), but after the allegation of abuse, their care level had changed. Together Inspector #690 and RPN #107 reviewed resident #001's care plan and Kardex on PCC. RPN #107 identified that the Kardex did not include the intervention to provide the specified level of assistance for care related to behavious and that it should as that was the document that the PSW staff would utilize to know what care to provide to the resident. RPN #107 further identified that registered staff would utilize the care plan to identify what interventions were in place for ADLs and that the interventions on the care plan did not provide clear directions to staff and that it should.

In an interview with Inspector #690, the Director of Nursing Services (DONS) indicated that staff would utilize the care plan and the Kardex on PCC to identify what assistance a resident required with ADLs. Together the DONS and Inspector #690 reviewed resident

#001's care plan and Kardex and the DONS identified that the care plan and Kardex did not provide staff with clear direction on the level of assistance that resident #001 required for ADLs and that it should have. [s. 6. (1) (c)]

Issued on this 16th day of August, 2019

[redacted]

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

Original report signed by the inspector.