Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l’inspection	Log #/ No de registre	Type of Inspection / Genre d’inspection
Oct 30, 2019	2019_772691_0019 (A1)	018101-19	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

Amended by JENNIFER NICHOLLS (691) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

To achieve compliance, the home has been granted an extension to compliance due date for order #001.

Issued on this 30th day of October, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 30, 2019	2019_772691_0019 (A1)	018101-19	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

Amended by JENNIFER NICHOLLS (691) - (A1)

Amended 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): October 01-09, 2019.

The following intake was inspected upon during the CIS inspection:

-One intake submitted to the Director regarding staff to resident abuse.

A Follow up Inspection (2019_772691_0020) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Co-Director of Nursing (Co-DON), Nurse Managers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioral Support Team, Environmental Service Manager, Environmental Services Team Member, Personal Support Worker (PSWs), 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, staff education records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone.

Physical abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "the use of physical force by anyone other than a resident that causes physical injury or pain."

A Critical Incident System (CIS) report was submitted to the Director on an identified date, regarding an allegation of staff to resident abuse. The CIS report identified that Registered Practical Nurse (RPN) #108 had witnessed Personal Support Worker (PSW) #115 being physically abusive to resident #001.

Inspector #691 requested to review the home's internal investigation records, which included written statements and video footage obtained from the date and time of the reported incident. In the written statements from RPN #108 and RN #116, they both indicated that PSW #115 stated they were physically abusive towards resident #001. The internal investigation notes further identified a disciplinary letter addressed to PSW #115 on an identified date.

A review of the home's policy # V11-G-10.00, titled "Abuse and Neglect of a Resident-Actual or Suspected", last reviewed January 2019, indicated that there was zero tolerance of abuse or neglect of the residents, and that the policy applied to all staff at the home.

Inspector #691 interviewed RPN #108, who indicated they witnessed PSW #115 being physically abusive towards resident #001 and further identified to the Inspector that resident #001 sustained a specified injury.

In an interview with the Director Of Nursing (DON), they indicated that the home's abuse policy had a zero tolerance of resident abuse. The DON identified that through their internal investigation process, and review of video footage, PSW #115 had been abusive in their actions towards resident #001. The DON further identified that the home failed to protect resident #001 from abuse. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

A CIS report was submitted to the Director on an identified date, regarding an allegation of staff to resident physical abuse, see WN #1 for further detail.

Inspector #691 was given staff education records titled "Abuse and Neglect of a Resident-Actual or Suspected" for the year of 2018, which indicated 100 per cent compliance was not achieved by staff members as required. A further review of records indicated that staff member #103 did not have the required training on, "Abuse and Neglect of a resident -Actual or Suspected".

The licensee's policy VII-G-10.00 policy titled, "Abuse and Neglect of a resident-Actual/ Suspected" last revised November 2013, stated that "upon hire and annually thereafter, all staff and volunteers will receive in-service education on the topic of abuse and neglect strategies to prevent abuse and neglect, and the reporting of abuse and neglect.

In an interview with the DON, Inspector #691 requested "Abuse and Neglect of a Resident-Actual or Suspected" education records for staff member #103. The DON indicated to Inspector #691 that staff member #103 was a staff member in an identified area of the home, and they did not receive the "Abuse and Neglect of a resident-Actual or Suspected". The DON further indicated they didn't realize that they were required to complete this education and identified this was not done as required. [s. 76. (2) 3.]

2. The licensee has failed to ensure that the persons who have received training under subsection (2) received retraining in the areas mentioned in that subsection at times or intervals provided for in the regulations.

A CIS report was submitted to the Director on an identified date, regarding an allegation of staff to resident physical abuse, see WN #1 for further detail.

Inspector #691 was given staff education records titled "Abuse and Neglect of a Resident-Actual or Suspected" for the year of 2018 which indicated not 100 percent compliance was achieved by direct care staff members as required.

Further review of records indicated that direct are staff member #118 did not have the required annual retraining on "Abuse and Neglect of a resident -Actual or Suspected".

The licensee's policy VII-G-10.00 policy titled "Abuse and Neglect of a resident- Actual/ Suspected" last revised November 2013, stated that "upon hire and annually thereafter, all staff and volunteers will receive in-service education on the topic of abuse and neglect strategies to prevent abuse and neglect, and the reporting of abuse and neglect.

In an interview with the DON, together with Inspector #691, they reviewed the staff education records for staff member #118. The DON identified that staff member #118 did not complete the mandatory retraining on abuse education as required annually and should have. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff at the home received training as required in this section, to be implemented voluntarily.

Issued on this 30th day of October, 2019 (A1)

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER NICHOLLS (691) - (A1)
Inspection No. / No de l'inspection :	2019_772691_0019 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	018101-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 30, 2019(A1)
Licensee / Titulaire de permis :	Victoria Village Inc. 76 Ross Street, BARRIE, ON, L4N-1G3
LTC Home / Foyer de SLD :	Victoria Village Manor 78 Ross Street, BARRIE, ON, L4N-1G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Krever

To Victoria Village Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 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. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with the Long-Term Care Homes Act, 2007, S.O. 2007, c.8 s. 19 (1).

Specifically the licensee must ensure:
a) Resident #001, and any other residents in the home are protected from abuse.

b) Conduct an education audit of all staff in the home to determine if they have received education/annual re-education on the home's policy to promote zero tolerance of abuse and neglect of residents.

c) Where deficiencies are identified, conduct the training and Maintain records of the re-training, including date (s), times, attendees, and material reviewed.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone.

Physical abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as “the use of physical force by anyone other than a resident that causes physical injury or pain.”

A Critical Incident System (CIS) report was submitted to the Director on an identified date, regarding an allegation of staff to resident abuse. The CIS report identified that Registered Practical Nurse (RPN) #108 had witnessed Personal Support Worker

(PSW) #115 being physically abusive to resident #001.

Inspector #691 requested to review the home's internal investigation records, which included written statements and video footage obtained from the date and time of the reported incident. In the written statements from RPN #108 and RN #116, they both indicated that PSW #115 stated they were physically abusive towards resident #001. The internal investigation notes further identified a disciplinary letter addressed to PSW #115 on an identified date.

A review of the home's policy # V11-G-10.00, titled "Abuse and Neglect of a Resident-Actual or Suspected", last reviewed January 2019, indicated that there was zero tolerance of abuse or neglect of the residents, and that the policy applied to all staff at the home.

Inspector #691 interviewed RPN #108, who indicated they witnessed PSW #115 being physically abusive towards resident #001 and further identified to the Inspector that resident #001 sustained a specified injury.

In an interview with the Director Of Nursing (DON), they indicated that the home's abuse policy had a zero tolerance of resident abuse. The DON identified that through their internal investigation process, and review of video footage, PSW #115 had been abusive in their actions towards resident #001. The DON further identified that the home failed to protect resident #001 from abuse. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of this issue was a level one, as this incident was isolated. The home had a level two compliance history with previous non compliance in a different subsection in the last 36 months.
(691)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2019(A1)

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 Health and 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 Health and 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 de la Santé et 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 de la Santé et 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 30th day of October, 2019 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by JENNIFER NICHOLLS (691) - (A1)

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