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

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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
Jul 22, 2020	2020_565647_0010	013173-20	Complaint

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

JENNIFER BROWN (647)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 13 - 17, 2020.

The following intake was completed in this Complaint inspection:

-one intake was related to a complaint submitted to the Director regarding care concerns.

Critical Incident System (CIS) inspection 2020_565647_0012 and Follow Up inspection 2020_565647_0011 were completed concurrently with this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Restorative Care Therapist, and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions, resident to resident interactions, and the provisions of care, reviewed internal documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible, was fully respected and promoted.

A complainant (resident) called the action line to report that their assisted device had not been repaired and the loaner assisted device that the home had provided had not met their needs. The resident further indicated that this had been an issue for approximately one year and due to the resident's medical conditions, they were unable to utilize the assisted device without being dependent on staff.

During an interview with Inspector #647, the resident indicated that they had an assisted device, however it had been non-functioning for a while. An external provider provided the resident a quote for the repairs to their assisted device, however the resident could not afford these repairs.

During an interview with the Restorative Care Therapist (RCT) they indicated that the resident researched and provided the home with an application from an external fundraising foundation to apply for funding to have the assisted device repaired. The RCT indicated that prior to the assisted device not functioning, the resident was more independent, and was able to mobilize around the home which included outdoor patios and garden areas.

During interviews with direct care staff members #101, #104, and #107, they all indicated that when the resident's assisted device was functional, the resident was dependent on staff to set up the assisted device, however, once done, the resident could manipulate their assisted device outside of their room and spend time outside as they wished. Direct care staff member #104, further added that the resident's abilities would vary with each day with their medical conditions.

Registered staff member #106, indicated to the Inspector that when the resident's assisted device was working, they were able to have more independence and seemed happier because they could come and go as they pleased. The RPN further indicated that the resident was not able to use the loaned assisted device due to their unpredictable episodes of their medical condition, therefore had become entirely dependent on staff to do what they used to do when their assisted device was functional.

In an interview with the Director of Care (DOC), they indicated that when the resident requested the application from the external fundraising foundation to be completed to apply for funding to assist in paying for the repairs, they presented the application to the physician. At the time of the application, approximately one year prior, the application was not completed as the physician felt there were no clinical indicators for the assisted device to be repaired. During the interview with the DOC, the Inspector accessed the application for funding to either repair or replace assisted devices. Together with the DOC, the application indicated that one of the qualifiers for acceptance was if the applicant had “age related problems”. When asked, the DOC indicated that the unpredictable episodes of their medical conditions that the resident had experienced, would meet the criteria, and therefore should have had the application completed.

The DOC further indicated to the Inspector that since the application was not completed to fund the repair of the assisted device, and since the resident was unable to use the loaned assisted device, the home had not promoted the resident’s independence to the greatest extent possible. [s. 3. (1) 12.]

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 the residents right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible, is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident beds have a firm, comfortable mattress that was at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care.

A complainant (resident) called the action line to report a concern with their assisted device. During the interview, the resident further added that their mattress was "bottoming out" and it felt as though "the foam was breaking down".

During an interview with the RCT they indicated that they oversee the process of replacing mattresses when they receive communication from the nursing staff member that a mattress was required to be repaired or replaced. The RCT further indicated that they did not recall any communication to them to report a mattress was required to be checked.

During an interview with the PSW Manager, they indicated that PSW's change the bed linen the first bath of every week. Their role is to look at the mattress for any rips, tears, etc. and report it to them or the RCT.

Together with the RCT, the Inspector went to the complainants room and stripped their bed and found the mattress was not in good condition. There was an area that measured 38" x 19" of peeled off plastic barrier that left an exposed area of thin mesh fabric that did not hold the integrity of the mattress together.

The PSW Manager and the DOC were called to the unit where they were shown the condition of the mattress. They both indicated that the condition of the mattress should have been reported when the linen was changed on the residents bed as the open area of peeled plastic would have caused the resident discomfort and would not have protected the foam from any moisture which could have caused the foam to break down as the complainant first indicated. The mattress was disposed of at the time of this observation and replaced with another. [s. 12. (2) (a)]

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 the resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care, to be implemented voluntarily.

Issued on this 22nd day of July, 2020

[redacted]

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

Original report signed by the inspector.