

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

**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 26, 2020	2020_772691_0022	014973-20	Critical Incident System

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**Licensee/Titulaire de permis**

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

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

Victoria Village Manor  
78 Ross Street BARRIE ON L4N 1G3

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

JENNIFER NICHOLLS (691)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): November 16-19, 2020.**

**The following intake was inspected upon during the CIS inspection;**

**-One intake submitted to the Director regarding an Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Nursing (DON), Associate Director of Nursing (ADON), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist, Personal Support Worker (PSWs), and residents.**

**The Inspector also conducted a daily tour of resident care areas, observed resident rooms, 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:  
Critical Incident Response  
Falls Prevention**

**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**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident had fallen, the post-fall assessment of the head injury routine (HIR) had been conducted.

A resident sustained a fall, was found by staff; and a HIR form was initiated. The resident's HIR forms showed that 44% of the HIR checks were not completed by staff.

Sources: the Resident's progress notes; the resident's Head Injury Routine forms; falls policy #VII-G-60.00 last revised November 2017; interviews with the RPN, the RN and the DON, as well as other staff. [s. 49. (2)]

***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 the licensee shall ensure that when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:**

**3. Actions taken in response to the incident, including,**

- i. what care was given or action taken as a result of the incident, and by whom,**
- ii. whether a physician or registered nurse in the extended class was contacted,**
- iii. what other authorities were contacted about the incident, if any,**
- iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and**
- v. the outcome or current status of the individual or individuals who were involved in the incident.**

**O. Reg. 79/10, s. 107 (4).**

### **Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed within 10 days the current status and outcome of resident's fall with injury.

A CIS report was submitted to the Director for a fall with head injury of a resident where the resident was taken to hospital.

The Director requested an amendment to the CIS report be submitted by a specified date to include the resident's return from hospital with status.

The DON indicated that they were responsible to submit and update the CIS reports, and further acknowledged the amendment was not submitted as requested within the specified time frame.

Sources: CIS report, resident's progress notes, MOHLTC-Critical Incident Reporting Policy #I-F-48.00 last revised May 2018, and an interview with the DON. [s. 107. (4) 3.]

***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 the licensee shall inform the Director within 10 days of the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.***

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**Issued on this 26th day of November, 2020**

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

**Original report signed by the inspector.**