Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: April 5, 2024	
Inspection Number: 2024-1398-0002	
Inspection Type: Critical Incident	
Licensee: Victoria Village Inc.	
Long Term Care Home and City: Victoria Village Manor, Barrie	
Lead Inspector Kim Byberg (729)	**Inspector Digital Signature** Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2024.04.05 10:54:15 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2, and 3, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:
-Intake: #00110383, related to infection prevention and control practices.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

A respiratory outbreak was declared by Public Health on a specific resident home area at Victoria Village Manor.

According to the IPAC Standard for Long-Term Care Homes (LTCHs) revised September 2023, section 10.4 (h), and (i), the licensee shall ensure that support is provided for residents to perform hand hygiene prior to receiving meals, and snacks for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

Two residents were not assisted to complete hand hygiene before a meal.

A resident stated that staff did not assist them to clean their hands prior to their meal.

A Personal Support Worker (PSW) stated that staff were to assist residents with hand hygiene before and after meals.

There was risk to residents in the home for transmission of microorganisms when staff did not assist residents with hand hygiene before meals.

Sources: Observations during the inspection, Interview with a resident, PSW, and IPAC lead. Review of the home's Hand Hygiene Policy #VIII G-40.00 revised June 2022, IPAC Standard revised September 2023, section 10.4 (h),and (i).
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WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to immediately inform the Director of a human coronavirus outbreak at Victoria Village Manor, which is a disease of public health significance as defined in the Health Protection and Promotion Act

Rationale and Summary

Public Health Declared a respiratory outbreak of human coronavirus on a specific home area of human coronavirus at Victoria Village Manor. The home did immediately not notify the Director at the Ministry of Long-Term Care (MLTC) as required.

The home's infection prevention and control (IPAC) lead stated it was an oversight and the outbreak should have been reported immediately.

Sources: Critical Incident (CI) report, the home's line listing report, interview with the the home's IPAC lead.
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