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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 9, 2024
Inspection Number: 2024-1398-0003
Inspection Type:
Complaint

Licensee: Victoria Village Inc.
Long Term Care Home and City: Victoria Village Manor, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 12-15, and 19-22, 2024

The following intake was inspected:
- Intake #00116365, related to a resident care and unexpected death

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Pain Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care when the resident's condition changed.

Rationale and Summary

A resident's SDM was not notified or there was a delay in being notified on multiple occasions, including when the resident received care that did not align with their plan of care, the resident's condition changed on more than one occasion and when the resident had a medical emergency.

The Director of Nursing (DON) said the resident's SDM should have notified when staff noted changes in the resident's condition.

By not informing or delaying to inform the resident's SDM when the resident's

condition changed, it limited the SDM's ability to participate fully in making decisions about the resident's care and it might have contributed to the delay in implementing appropriate interventions.

Sources: a resident's clinical records, and interviews with staff and the DON.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care to a resident had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

The DON was informed of an incident of improper care of a resident.

The DON said this incident was not reported to the Director.

By not reporting immediately to the Director the incident related to a resident's improper care, it limited the Director's ability to respond to the incident.

Sources: a resident's clinical records, the home's investigation notes, and interviews with the DON and other staff.

WRITTEN NOTIFICATION: Dining and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that their meal service included elements to ensure food and fluids were served at a temperature that was safe and palatable for the residents.

Rationale and Summary

The home's policy Food temperatures -Point of Service documented staff responsibilities and actions to be implemented to ensure the minimum food temperatures, however it did not include any information related to the maximum food temperatures.

A resident sustained an injury when they spilled a food item on themselves. The temperature of the food item was recorded, however there was no indication of the actions taken to ensure the temperature was both safe and palatable for the resident.

The home's Food Services Manager acknowledged that there was no formal process to ensure the maximum safe temperature for food to be served and to communicate this to staff and residents.

Staff not ensuring the food was served at a temperature that was both safe and palatable for residents resulted in harm to a resident.

Sources: a resident's clinical records, food temperature -point of service record, Food Temperatures-Point of service, policy, and an interview with the Food Services Manager.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
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):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately informed of a resident's sudden death.

Rationale and Summary

A resident passed away suddenly while they were provided care by staff. The death was reported to the coroner and the resident's record of death indicated the death was unexpected.

By not reporting immediately to the Director the incident of sudden death of a resident, it limited the Director's ability to respond to the incident in a timely manner.

Sources: a resident's clinical records, Resident Death Notice, and an interview with the DON.

WRITTEN NOTIFICATION: Exceptions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 254 (5)
Exceptions
s. 254 (5) If a staff member was hired or a volunteer was accepted during a pandemic before this section came into force and no police record check that complied with subsections 215 (2) and (3) of Ontario Regulation 79/10 (General) made under the former Act was provided to the licensee, the licensee shall ensure that a police record check that complies with subsections 252 (2) and (3) of this Regulation is provided to the licensee within three months after this section comes into force and the licensee shall keep the results of the record check in accordance with the requirements in section 278 or 279 as applicable.

The licensee has failed to ensure that a Registered Practical Nurse (RPN) who was hired during a pandemic, had a police record check submitted to the home within three months after section 254 of O. Reg. 246/22 came into force.

Rationale and Summary

A Registered Practical Nurse (RPN) was hired during a pandemic, and their employment finished three years later.

At the time of this inspection, there was no record of the police record check in the employee's file.

The DON confirmed that a police record check was not in the RPN's file, as required.

The home's failure to ensure that an RPN who was hired during a pandemic, had a police record check submitted to the home within three months after section 254 of O. Reg. 246/22 came into force, posed a potential risk to residents as it may result in hiring of an employee with documented criminal behavior towards vulnerable individuals.

Sources: employee file of an RPN, and an interview with the DON.

WRITTEN NOTIFICATION: Emergency plans

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (5) 4.
Emergency plans
s. 268 (5) The licensee shall ensure that the emergency plans address the following components:
4. Specific staff roles and responsibilities.

The licensee has failed to ensure staff complied with their specific medical emergency roles and responsibilities when a resident had a medical emergency.

In accordance with O. Reg 246/22, s. 11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

Rationale and Summary

The home's policy for medical emergencies documented specific responsibilities for staff to follow according to their roles when responding to a resident medical emergency.

A resident had a medical emergency, and staff did not follow the interventions specified in the resident's Advance Directives and their roles and responsibilities as indicated in the home's procedure for medical emergencies.

When staff failed to comply with their specific medical emergency roles and responsibilities, it had prevented timely assistance from available nursing resources and increased the likelihood of adverse outcomes.

Sources: a resident's clinical records, the home's medical emergency policy, and interviews with staff and the DON.

COMPLIANCE ORDER CO #001 Duty to protect

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that:

1) Provide retraining to a PSW regarding the home's responsive behaviours policy and procedures

2) Provide retraining to all registered nursing staff working on the specified Resident Home Area (RHA) regarding the home's policies and procedures related to pain management, skin and wound care, medication management, medical emergency procedure and communication with the Physician and Nurse Practitioner (NP) or Physician Assistant (PA).

3) Document the training provided to the staff members, including the date, the name of the staff members who attended and who provided the training, the content of the education and the method used to assess staff understanding and knowledge. A record of the training should be kept at the home.

4) Conduct daily audits for four weeks on the specified RHA, to ensure that when a resident has new pain or pain not relieved by the initial interventions and/or any new areas of altered skin integrity, registered nursing staff are:
a) completing the required assessments
b) providing appropriate interventions
c) communicating immediately with the Physician, NP or PA when a resident's pain is worsening, or not being relieved by initial interventions

5) Document the audits, including the date and time, the resident name, staff who completed the audit, staff members audited, elements checked during the audit, and any actions taken based on the audit results. A copy of the audit should be kept at the home.

Grounds

The licensee has failed to ensure that a resident was protected from neglect by staff members.

For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

A resident sustained an injury when a staff did not follow the resident's plan of care.

Despite the resident's ongoing pain and deterioration of their condition on more than one occasion after the incident, staff did not complete the required assessments and interventions, including lack of comprehensive pain and skin assessments, errors or delays in processing the Physician Assistant's order and following the recommendations from the hospital, delays in informing the Physician or the Physician Assistant about the resident's ongoing pain and worsening of their condition and delays in implementing the emergency procedures when the resident had a medical emergency.

The DON said staff should have implemented the required actions when they noted worsening in the resident's condition and should have followed the emergency procedure as specified in the home's policy.

When staff failed to follow a resident's plan of care, it resulted in the resident sustaining an injury. The pattern of inaction from the staff after the incident, impacted the resident's quality of life and may have contributed to their death.

Sources: a resident's clinical records, hospital records, investigation notes, and staff interviews.

This order must be complied with by October 4, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.