

**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

## Amended Public Report Cover Sheet (A1)

<b>Amended Report Issue Date:</b> October 2, 2025
<b>Original Report Issue Date:</b> September 23, 2025
<b>Inspection Number:</b> 2025-1398-0005 (A1)
<b>Inspection Type:</b> Complaint Critical Incident Follow up
<b>Licensee:</b> Victoria Village Inc.
<b>Long Term Care Home and City:</b> Victoria Village Manor, Barrie

## AMENDED INSPECTION SUMMARY

This report has been amended to:  
Written Notification (WN) # 002 was amended to correct the date the clinically appropriate skin assessment was completed in the grounds of the report.

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## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10-12, 15-19, 22, and 23, 2025.

The following intake(s) were inspected:

-Intake: #00148250, Follow-up Compliance Order #: 1, O. Reg. 246/22 - s. 102 (2) (b) related to the Infection Prevention and Control Program.

-Intake: #00153685, and Intake: #00153991, related to an allegation of resident-

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to-resident abuse.

-Intake: #00154290, concerns related to respecting resident's bill of rights.

-Intake: #00155761, related to the fall prevention program.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1398-0003 related to O. Reg. 246/22, s. 102 (2) (b)

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

## AMENDED INSPECTION RESULTS

### WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 34 (2)**

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident

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under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that when a resident had an alleged inappropriate encounter with a co-resident, that the home documented assessments of each resident to determine if the encounter was consensual.

**Sources:** review of residents' progress notes, assessments, and interview with staff.

## **WRITTEN NOTIFICATION: Skin and wound care**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a resident received a skin assessment using a clinically appropriate assessment instrument specifically designed for skin and wound assessments when they returned from the hospital with areas of impaired skin integrity.

A resident returned from the hospital with new areas of impaired skin integrity. A skin and wound assessment was not completed until ten days after they returned to the home.

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**Sources:** review of a residents skin assessments, progress notes, skin and wound care policy VII-G-20.10 revision date July 2017, electronic medication administration record and interview with staff.

## **WRITTEN NOTIFICATION: Altercations and other interactions between residents**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 59 (b)**

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee has failed to ensure that steps were taken by the home to minimize the risk of altercations and potentially harmful interactions between residents when interventions were not implemented that promoted safety of a resident.

A resident had two altercations with co-residents that resulted in injuries to the resident. When the home failed to implement effective measures to promote a safe environment, the resident continued to be at risk for potentially harmful interactions with co-residents.

**Source:** progress note, care plan, Responsive behaviours policy (ID: 5.6.6. revised date April 11, 2025), interview staff.



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