

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

Public Report

Report Issue Date: November 19, 2025
Inspection Number: 2025-1398-0006
Inspection Type: Complaint Critical Incident
Licensee: Victoria Village Inc.
Long Term Care Home and City: Victoria Village Manor, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 5-7, 12-14, 18 and 19, 2025.

The following intake(s) were inspected:

- Intake: #00158781 - a critical incident related to an altercation between residents resulting in injury.
- Intake: #00159233 - a critical incident related to a fall resulting in a fracture.
- Intake: #00159849 - a complaint regarding allegation of physical abuse, medication administration and care concerns.
- Intake: #00160258 - a critical incident related to an injury of unknown cause.

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

- Resident Care and Support Services
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #001 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.

Interventions were not implemented to minimize the risk of altercations and potentially harmful interactions between two residents.

There was an altercation between the two residents that resulted in an injury.

Sources: resident clinical records, Critical Incident Report, interviews with Personal Support Workers.

WRITTEN NOTIFICATION: Administration of drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

Drugs were not administered to a resident in accordance with the directions for use specified by the prescriber.

a) A resident was administered a medication that was not part of their drug regimen.

Sources: Progress Notes, Medication Incident Report, interview with a Registered Practical Nurse (RPN).

b) On an identified date, a resident was not administered a medication as specified by the prescriber.

Sources: Progress Notes, Care Plan, Interview with Personal Support Worker (PSW).