Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 6, 2018 | 2018_638609_0009 | 007012-18 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

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

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

Victoria Village Manor
78 Ross Street BARRIE ON L4N 1G3

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

CHAD CAMPS (609), JENNIFER BROWN (647), RYAN GOODMURPHY (638)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): April 30, May 1-4, and May 7-11, 2018.**

**Additional intakes inspected during this RQI included:**

**One intake related to Compliance Order (CO) #001 from inspection #2018_565647_0009, s. 44. of the Long-Term Care Homes Act (LTCHA), 2007, specific to the admission of residents to the home;**

**One intake related to CO #001 from inspection #2017_491647_0019, s. 131. (1) of the Ontario Regulation (O.Reg.) 79/10, specific to the administration of drugs;**

**Two complaints related to the care of a resident;**

**Two complaints related to the admission of residents to the home;**

**Six Critical Incident (CI) reports submitted by the home to the Director related to resident falls;**

**Two CI reports submitted by the home to the Director related to resident to resident abuse; and**

**One CI report submitted by the home to the Director related to staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Nursing/Acting Administrator (Administrator), Assistant Director of Nursing/Acting Director of Nursing (DON), Director of Resident and Family Services, Volunteer Coordinator, Dietary Manager, Restorative Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family of residents.**

**The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigations and reviewed numerous licensee policies, procedures and programs.**

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

**Admission and Discharge**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **10 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 131. (1) | CO #001 | 2017_491647_0019 | 647 |
| LTCHA, 2007 S.O. 2007, c.8 s. 44. | CO #001 | 2018_565647_0009 | 647 |

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A Critical Incident (CI) report was submitted by the home to the Director which outlined how on a particular day, resident #015 fell when they were left alone by PSW #119. The resident was left alone after the PSW provided the resident with supplies and told to complete their own activities of daily living (ADLs).

Resident #015 was subsequently transferred to the hospital and diagnosed with a significant change in health condition.

Inspector #609 reviewed resident #015's Minimum Data Set (MDS) assessment and found that the resident had a history of falls and required assistance for ADLs.

A review of resident #015's communication tool which instructed staff about the resident's care needs, indicated that the resident could toilet self, while a review of resident #015's healthcare records found that the resident was identified as a falls risk

and required assistance with ADLs.

During an interview with RPN #114, they verified that they completed resident #015's communication tool, which was based on information provided to them by the resident's family. They went on to outline how the family told them that the resident was not independent with ADLs. The RPN reviewed the communication tool with the Inspector and verified that they incorrectly completed the tool, identifying that the resident was independent when they were not.

RPN #114 also acknowledged that they had not considered any of the MDS information when they completed resident #015's communication tool.

A review of the home's policy titled "Resident Assessments" last revised July 2017 required all those involved in resident assessment and care planning to communicate identified risk to the resident and other team members as applicable.

During an interview with the Inspector, the DON reviewed resident #015's health care records as well as the previous interview with RPN #114. They verified that the RPN should have advised staff that the resident was not independent with ADLs.

During an interview with PSW #119, they described how resident #015 was refusing care on the particular day. After multiple attempts to have the resident complete care, they left them alone after setting out supplies and providing ADL instructions to the resident. Several minutes later they found the resident on the floor.

When asked how they knew resident #015 was independent with ADLs, PSW #119 outlined how they reviewed information provided on report by the RPN.

During an interview with the Administrator, a review of the CI report, resident #015's healthcare records and communication tool as well as interviews with RPN #114 and PSW #119 were conducted. They verified that the information obtained by the RPN, the communication tool and the healthcare records were not consistent with each other.

The Administrator also acknowledged that had the assessments been consistent, resident #015 would not have been left alone to perform their own ADLs. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the following were documented: 1. The provision of the care set out in the plan of care; The outcomes of the care set out in the plan of

care; and The effectiveness of the plan of care.

Inspector #647 identified resident #006 as having altered skin integrity, through a staff interview.

Inspector #638 reviewed resident #006's health care records and identified in their current care plan, that the resident had altered skin integrity requiring treatment. The Inspector reviewed the previous health care records for a specified time frame and was unable to identify any completed skin assessments related to the resident's altered skin integrity.

In an interview Inspector #638, RN #102 indicated that whenever a resident developed a new area of altered skin integrity, staff were supposed to assess the area and notify the wound care nurse for interventions. The RN stated that an area of altered skin integrity was reassessed with each dressing change and documented in the assessments tab of Point Click Care (PCC).

During an interview with Inspector #638, RPN #108 (wound care nurse) indicated that areas of altered skin integrity were supposed to be reassessed with each dressing change or weekly, at a minimum. The RPN indicated that the assessments were documented in the assessments tab of PCC. The RPN reviewed resident #006's health care records with the Inspector and stated they were unable to locate any completed skin assessments in relation to the resident's areas of altered skin integrity for the previous three months.

The home's policy titled "Skin and Wound Care Management Protocol" last revised July 2017 indicated that registered staff would set up in the Electronic Medication Administration Record (eMAR) a reminder to complete a Skin Care Assessment under the assessments tab (in PCC). The policy further identified that registered staff were to adhere to the protocols as specified.

In an interview with Inspector #638, the Administrator indicated that residents' areas of altered skin integrity were supposed to be reassessed with each dressing change or weekly. The Administrator stated that the assessments were documented under the assessments tab on PCC as they had a template for the assessment. The Inspector reviewed resident #006's health care records with the Administrator, who indicated that registered staff should have been documenting an assessment for the resident's altered skin integrity. [s. 6. (9)]

***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 to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, especially in the care required by residents within the first 24 hours of their admission, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Verbal abuse is defined within the O. Reg. 79/10, as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

A complaint was submitted to the Director which alleged an incident of staff to resident abuse. The complainant indicated that PSW #116 and PSW #117 were providing care to resident #009, when they overheard PSW #116 threaten the resident. The complainant further indicated that they witnessed the PSW screaming at the resident and holding their wrist.

Inspector #638 reviewed the internal investigation notes and identified an interview between the Administrator, DON and PSW #116. The interview notes indicated that the PSW was providing care to the resident, who at the same time was demonstrating responsive behaviours.

The Inspector reviewed a letter which was hand delivered to PSW #116. The letter indicated that as a result of the investigation the home determined that PSW #116 made an inappropriate comment in reaction to the resident's responsive behaviours and the comment made was determined to be verbal abuse.

In an interview with Inspector #638, PSW #116 indicated that they were providing care to resident #009, while the resident was demonstrating responsive behaviours. PSW #116 verified that when the resident demonstrated responsive behaviours on the particular day, they threatened the resident. PSW #116 indicated they were having a busy day and was overwhelmed, however, they stated they realized this was no excuse and they should not have taken this approach.

During an interview with Inspector #638, RPN #123 indicated that they were made aware of an incident of alleged verbal abuse on the particular day.

The home's policy titled "Abuse & Neglect of a Resident" last revised September 12, 2017, indicated that the home had a zero tolerance of abuse and neglect of residents, that every resident had the right to be protected from abuse and that every resident was to be treated with courtesy and respect.

In an interview with Inspector #638, the Administrator indicated that PSW #116 was investigated for verbally abusing resident #009, found that the PSW had not complied with the home's policy to promote zero tolerance of abuse of residents and was disciplined accordingly. [s. 20. (1)]

***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 to ensure that PSW #116 complies with the home's written policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

A CI report was submitted to the Director which outlined how on a particular day resident #011 had a physical altercation with resident #010 in a specified location. Staff found that resident #011 had sustained an injury in the altercation.

Inspector #609 further reviewed the CI report which indicated that resident #011 had a history of aggression triggered in the specified locations.

A review of all resident #011's interdisciplinary care conference notes found that two months after the CI, the home further verified that the resident would enter the specified locations and exhibit aggressive responsive behaviours towards co-residents.

A review of resident #011's physician note six months after the CI, indicated that the

resident would enter the specified locations and could become physically responsive.

A review of every Minimum Data Set (MDS) assessment for resident #011 from admission to present, failed to mention the resident's identified responsive behaviours.

A) A review of resident #011's health care records prior to the CI report, found that on a particular day, the resident entered one of the specified locations and had a physical altercation with a co-resident.

Despite the identified responsive behaviours prior to the CI, resident #011's plan of care at the time of the CI report, found no mention that the resident would enter the specified locations and become physically aggressive towards co-residents.

B) A review of resident #011's health care records since the CI to the present, found in progress notes that the resident exhibited verbally and physically responsive behaviours towards co-residents as well as entered the specified locations in 16 additional incidents.

During an interview with PSW #110, they outlined how resident #011 could become confused and enter the specified locations. The PSW verified that the resident could also become physically responsive towards co-residents.

A review of the home's policy titled "Identification and Management of Responsive Behaviours" last revised June 2017 required the plan of care be updated with individualized interventions that addressed responsive behaviours.

During an interview with RPN/Behavioural Supports Ontario (BSO) #103, a review of resident #011's health care records and plan of care were conducted. They verified that the resident would enter the specified locations as well as become verbally and physically responsive towards co-residents. The RPN/BSO verified that the resident's plan of care did not identify that the resident would enter specified locations, nor identify that they could become verbally and physically responsive towards co-residents.

During an interview with the DON a review of resident #011's health care records and plan of care were conducted. They verified that the resident's identified responsive behaviours should have been included in the plan of care and that this did not occur. [s. 26. (3) 5.]

***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 to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CI report was submitted to the Director which indicated that on a particular day, PSW #118 and PSW #122 were providing resident #009 with a bath. Once lifted into the tub, PSW #122 left PSW #118 to complete the bath. The CI report outlined how PSW #118 did not use the equipment required to maintain the resident's safety while bathing and as a result may have injured the resident.

Inspector #638 reviewed resident #009's health care records and identified in their care plan that the resident required two person assistance for transfers, while their MDS indicated that they could not balance without assistance.

The Inspector reviewed a progress note which indicated that resident #009 was sent on the particular day to hospital for investigation into possible injury.

Review of the human resources files indicated that PSW #122 failed to follow the nurse's instructions in regards to being the second PSW present in the tub room when providing care to resident #009, which placed the resident at risk and compromised the care that

they received.

During an interview with Inspector #638, RPN #103 indicated that they responded to a call bell on the particular day and found PSW #118 in the tub room with resident #009 sitting at the bottom of the empty tub, in visible distress. The RPN indicated that the PSW did not use the equipment required to maintain the safety of the resident when they were bathing.

The home's policy titled "Hygiene, Personal Care and Grooming" last revised July 2017, indicated that for the actual bathing procedure staff were to "refer to text for: giving a bath in a commercial whirlpool tub". The text titled "Procedure 18-3: Giving a Bath in a Commercial Whirlpool Tub" stated that the resident was to be seated in the bath lift and be sure the safety waist belt was in place. The text further stated that the safety belt was to be removed only when the client was safe to move into a chair.

In an interview with the Administrator, they indicated that when providing a resident with a tub bath, direct care staff were supposed to use either the tub chair, which had a seat belt to secure the resident in position or to suspend them in the mechanical lift. The Administrator indicated that safe transferring and positioning techniques were not used once the resident was in the tub and PSW #118 was on their own. The Administrator indicated that PSW #118 was provided with additional training on safe transferring and positioning techniques to ensure that the incident would not reoccur. [s. 36.]

***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 to ensure that staff used safe transferring and positioning devices or techniques when assisting residents, especially when providing bathing assistance, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

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

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #609 reviewed the home's last three Residents' Council meeting minutes and found:

In the January 2018 meeting minutes, the home responded two months later to dietary concerns brought forward in the November 2017 Residents' Council meeting, related to shortages of hot cereals; and

In the March and April 2018 meeting minutes, various dietary concerns were identified which included but was not limited to poor tasting coffee, meat being too tough to chew and improving the quality of the evening meals.

The Inspector could not locate any written response within 10 days to the Residents' Council's identified dietary concerns.

A review of the home's policy titled "Residents' Council" issued November 2013 required suggestions and complaints from the Residents' Council be responded to in writing within 10 days and be posted in an action memo accessible to the Residents' Council.

During an interview with the Volunteer Coordinator and assistant to the Residents' Council, they outlined how concerns brought forward in Residents' Council should be responded to in writing in an action memo by the appropriate department manager within 10 days.

During an interview with the Dietary Manager a review of the last three Residents' Council meeting minutes was conducted. They described that dietary concerns brought forward in Residents' Council were responded to verbally at the time or by the next scheduled meeting, which could be up to one month later.

A review of the Regulation was conducted with the Dietary Manager who verified that dietary concerns brought forward in Residents' Council should be responded to in writing within 10 days, that this had not occurred. [s. 57. (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 to ensure that they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

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

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Record review of the following two medication incident reports and the progress notes for resident #026 and #027 revealed the following:

On a particular day, resident #027's Substitute Decision Maker (SDM) and physician were not notified of a medication error.

On another particular day, resident #026's SDM and physician were not notified of a medication error.

In an interview with the Administrator, they acknowledged that the SDMs and the physician were not notified at the time of the medication incidents. The DOC further confirmed the home was required to notify the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider relating to all medication incidents. [s. 135. (1)]

***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 to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident had the right to live in a safe and clean environment.

A complaint was submitted to the Director which alleged various care concerns regarding resident #009. The complaint indicated that the family frequently found the resident's bed made even though the linens were soiled. The complainant alleged that staff only changed bedding on bath days.

a) Inspector #638 observed resident #009's room on a particular day and noted a strong odour of urine in the resident's room and a large wet spot on the lower sheet.

In an interview with Inspector #638, PSW #120 stated that bedding was changed on a resident's bath day to ensure they have clean bedding. The PSW indicated that if the bedding was soiled or had a foul odour, it would be changed as needed. The Inspector observed resident #009's bedding with the PSW who indicated that there was a strong urine odour and they would have changed the bedding if they were providing this resident's care.

Inspector #638 interviewed PSW #121 who indicated that they were responsible for resident #009's care on the particular day. The PSW indicated that the wet spot was from wet face cloths and that the urine odour was a result of the mattress cover being soiled with urine in the past. The PSW indicated that they could order a new mattress pad, however, there was not always a spare cover available, so they just made the bed.

b) Inspector #638 observed resident #009's bed on another particular day and noted that the resident's bed was made. Upon pulling back the top sheet and clean incontinent pad, the Inspector noted a large soaked area on the bottom sheet, which had a strong urine odour. The Inspector also noted a large dollop sized stain of what appeared to be dried sputum on the left side of the bottom sheet.

The Inspector and the Administrator observed resident #009's bed on the particular day. The Administrator indicated that staff should not have applied a new incontinence pad over the wet urine spot on the bottom sheet. The Administrator verified that there was additional bedding available for the resident's bed and indicated that it should have been changed.

In an interview with Inspector #638, the Administrator indicated that it was part of the PSWs' daily routine to check bedding. The Administrator indicated that the direct care staff should change bedding whenever it was soiled and that additional mattress covers were available. The Administrator stated that resident #009's bedding should have been changed when it was soiled and agreed that resident #009's right to live in a clean environment was not fully promoted as a result of the aforementioned observations. [s. 3. (1) 5.]

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur was immediately reported and the information upon which it was based to the Director.

A CI report was submitted to the Director regarding an incident of resident to resident abuse where resident #007 sustained an injury as a result of resident #008's physically responsive behaviours.

The Inspector reviewed resident #008's health care records and identified in the progress notes an entry which indicated on a particular day, that the resident had a physically responsive incident with resident #007.

Inspector #638 reviewed resident #007's health care records and identified in the progress notes an entry which indicated that staff found the resident on the particular day with obvious injuries.

During an interview with Inspector #638, RPN #103 indicated that they responded to the incident and reported the incident on the same day to the Administrator.

The home's policy titled "Abuse & Neglect of a Resident – Actual or Suspected" last revised September 12, 2017, indicated that all staff members have an obligation to report any incident or suspected incident of resident abuse to the Administrator immediately and further staff may notify the Ministry of Health by using the toll free number posted on the board in the front lobby.

Inspector #638 interviewed the Administrator who indicated that whenever an incident of resident to resident abuse occurred and there was an injury to the resident, the incident was supposed to be immediately reported to the Director. The Administrator indicated that the after-hours pager was not called at the time of the incident and should have been. [s. 24. (1) 2.]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence**

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

**s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with the condition of the LTCHA that the licensee shall comply with every order made under the Act.

On April 6, 2018, CO #001 from inspection #2018_565647_0009 was served under LTCHA, 2007 S.O. 2007, c.8, s. 44 relating to authorization for admission to a home:

The licensee must be compliant with s.44 of the LTCHA.

Specifically, the licensee shall:
1. Cease the practice of withholding an applicant's approval unless:
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44 (7)

2. Immediately contact the appropriate placement coordinator at the North Simcoe Muskoka Local Health Integration Network to request the most recent MDS assessments for applicants #001, #002, #003, #004, and #005 if the applicants are still choosing Victoria Village Inc.

3. Accept applicants #001, #002, #003, #004, and #005 unless as specified by this legislation.

4. Should the licensee withhold approval, the licensee must meet the requirements of s. 44 (9) of the LTCHA and provide a notice addressing:
(a) the ground or grounds on which the licensee is withholding approval;
(b) a detailed explanation of the supporting facts, as they relate both to the home and to

the applicant's condition and requirements for care;
(c) an explanation of how the supporting facts justify the decision to withhold approval; and,
(d) contact information for the Director. 2007, c. 8, s. 44 (9).

5. Implement change to the approval process of applications whereby, the Licensee is involved in the decision to withhold or accept.

The compliance dated was April 30, 2018.

The licensee failed to complete step 2 specifically:

2. Immediately contact the appropriate placement coordinator at the North Simcoe Muskoka Local Health Integration Network to request the most recent MDS assessments for applicants #001, #002, #003, #004, and #005 if the applicants are still choosing Victoria Village Inc.

During an interview with the Director of Resident and Family Services, they acknowledged that the CO #001 from inspection #2018_565647_0009 had been verbally discussed over the telephone on April 6, 2018, between Inspector #647, the Director of Resident and Family Services and the DON. The Director of Resident and Family Services further indicated that they had received the report on April 6, 2018, via fax.

During a further interview with the Director of Resident and Family Services, they indicated that part two of the above mentioned requirements had not been completed as they were not aware they were included in the CO.

During an interview with the Administrator, they indicated that they had been on vacation as of April 7, 2018, and upon their return did not read the CO report from inspection #2018_565647_0009. The Administrator further indicated that step two had not been completed. [s. 101. (3)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation**

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

**s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review completed on May 7, 2018, by Inspector #647 of the Quality Management – Program/Committee Evaluation tool that had been completed in January, 2018, revealed that it had been completed by the Administrator.

During an interview with the Administrator, they indicated that the above required staff did not participate in an annual meeting to evaluate the effectiveness of the medication management system in the home. [s. 116. (1)]

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**Issued on this 21st day of June, 2018**

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

**Original report signed by the inspector.**