Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 8, 2019	2019_746692_0017	012974-19	Critical Incident System

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

SHANNON RUSSELL (692), TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 4-5, 2019.

The Following intake was inspected upon during this Critical Incident System Inspection:
-One log related to a critical incident report that the home submitted to the Director for a missing resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Services (DONS), Maintenance workers, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and 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 interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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 O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres (cm).

On March 14, 2019, the Director informed licensees via a memo regarding the safety of the windows located in resident rooms. The memo highlighted that the windows in the home that opened to the outdoors and was accessible to residents, were to have a screen and could not be opened more than 15 cm. The memo asked homes to inspect their windows to make sure that residents were not able to open them beyond 15 cm in any way, and if they were able to, the home was to address the problem to meet the requirements of the Long-Term Care Homes Act (LTCHA).

The home submitted a Critical Incident System (CIS) report on an identified date, related to a missing resident who had eloped from the home. The CIS report identified that on a specified date, resident #001 had been found by a Personal Support Worker (PSW) outside the home and was returned to the unit with no injuries. The CIS report further indicated that through an internal investigation they determined that resident #001 had eloped out of a window on the unit in which they resided. The CIS report indicated that all of the windows on the unit where resident #001 went out the window would be amended with a mechanism that prevented the window from being opened more than 15cm.

Inspector #692 reviewed resident #001's health care records, in which the care plan identified a focus of an "Elopement Risk" as they had attempted to exit the home unsupervised on a few occasions. The care plan identified staff were to implement specific interventions to mitigate the risk of the resident eloping.

A further review of resident #001's progress notes by Inspector #692, identified that on a specified date, Registered Practical Nurse (RPN) #107 was notified that the resident had been found outside the home, and was returned with no identified injuries after completing an assessment of the resident. RPN #107 documented that they notified the Director of Nursing Services (DONS) and staff would be completing specific interventions until the windows could be assessed and new mechanisms applied.

Inspectors #692 and #690 conducted a review of the windows on the unit that resident #001 resided on and noted that all the windows would slide horizontally to open. The windows in 10 rooms were inspected and noted that they all had screens in place, and a metal mechanism attached to the frame of the tracking that stopped the windows from opening more than 9 cm.

The Inspectors conducted a review on the other three units, which identified all the windows on those units were the same type as on the other unit. There were 12 rooms

assessed on one floor, eight rooms assessed on another floor and 10 rooms assessed on the remaining floor. The assessed windows were observed to have a metal lever attached to the window frame that when pulled downward (with little force), allowed the windows to be opened more than 15 cm. The window openings ranged between 33 cm to 48.5 cm.

In interviews with Maintenance #101 and #102, they stated to the Inspectors that previous to the incident where resident #001 eloped, they believed that the metal lever would prevent the windows from being opened more than 15 cm. They indicated that when the incident occurred they were told by the DONS to assess the windows on the unit that resident #001 resided, and determined that the metal lever could be pulled downward very easily, which enabled the window to be opened more than 15 cm. Maintenance #102 identified that they applied a metal mechanism attached to the frame of the tracking on all the windows of the unit that resident #001 resided, which prevented the windows from opening more than 9 cm. They identified that they were not told to assess or modify the other three units windows. They confirmed that all the windows did not have the metal mechanisms on those three floors, and therefore could be opened more than 15 cm.

In an interview with Inspectors #690 and #692, the Administrator indicated that they were aware of the memo regarding the safety of the windows located in resident rooms. The home had not conducted an inspection of the windows at that time as they assumed that the metal lever that was in place since the opening of the home, was sufficient in not allowing the windows to be opened more than 15 cm. When the incident involving resident #001 occurred they became aware that the windows could be opened more than 15 cm by a resident. Together, the Inspectors and the Administrator observed windows on the other three units, where the Administrator confirmed the windows on those units could be opened more than 15 cm. The Administrator confirmed that all windows on the three floors did not meet the current legislation related to window safety, and that it should. [s. 16.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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, any person who had reasonable grounds to suspect that abuse of a resident had occurred, immediately reported the suspicion and information upon which it was based to the Director.

A CIS report was submitted to the Director for an incident related to a resident that was missing from the home. The CIS report indicated that resident #001 had eloped from a window in the home. Please see WN #1 for details.

A review of resident #001's electronic care plan identified that the resident had responsive behaviours that included exit seeking and responsive behaviours towards co-residents. The care plan indicated that staff were to implement specific interventions to mitigate the behaviour.

Inspector #690 conducted a review of resident #001's electronic health records and identified a progress note documented on a specific date by RPN #107, that indicated that resident #001 was observed exhibiting responsive behaviours towards resident #002. Staff intervened and directed resident #001 away from resident #002.

Inspector #690 reviewed CIS reports made to the Director through the Ministry of Health and Long-Term Care (MOH&LTC) on-line critical incident reporting portal and noted that a CIS report had not been submitted regarding the aforementioned incident.

A review of the home's policy titled "Abuse and Neglect of a resident-Actual or Suspected-V-G-10.00", dated November 2013, indicated that any incident with respect to alleged, suspected or witnessed abuse of a resident would be immediately reported to the Director.

In an interview with Inspector #690, PSW #106 indicated that resident #001 had a history of responsive behaviours towards co-residents. PSW #106 indicated that they monitored resident #001 and if they witnessed resident #001 exhibiting responsive behaviours, they were to redirect the resident away from the co-resident and report to the Charge Nurse (CN) right away.

In an interview with Inspector #690, RPN #107 identified that resident #001 had a history of responsive behaviours and that they had been working on the identified date, when staff reported to them that resident #001 had been exhibiting responsive behaviours towards resident #002. RPN #107 indicated that resident #002, did not “seem distressed” at the time, but that they were not sure if the incident would be considered abuse, so they reported the incident to the DONS right away.

In an interview with Inspector #690, the DONS indicated that they were made aware of the incident on the identified date, by RPN #107, but based on the information from RPN #107, they considered that resident #002 had not been distressed at the time, and they did not report the incident to the Director. The DONS indicated that the incident between resident #001 and #002 could be considered an allegation of abuse. The DONS further indicated that the expectation would be that any alleged, suspected or actual abuse would be reported to the Director immediately and then investigated to determine if the incident was actual abuse. [s. 24. (1) 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 any person that has reasonable grounds to suspect that abuse of resident that has occurred, immediately report the suspicion and information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 10th day of July, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHANNON RUSSELL (692), TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2019_746692_0017
Log No. / No de registre :	012974-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 8, 2019
Licensee / Titulaire de permis :	Victoria Village Inc. 76 Ross Street, BARRIE, ON, L4N-1G3
LTC Home / Foyer de SLD :	Victoria Village Manor 78 Ross Street, BARRIE, ON, L4N-1G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Krever

To Victoria Village Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee must be in compliance with s. 16 of the Ontario Regulation 79/10.

Specially the licensee must:

a) Create and implement an audit to be completed on every window in the home to ensure that no window in the home that is accessible to residents can be opened more than 15 cm and is equipped with a screen.

b) Maintain a record of the results, discrepancies and the follow up completed with the outcome.

Grounds / Motifs :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres (cm).

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previous to the incident where resident #001 eloped, they believed that the metal lever would prevent the windows from being opened more than 15 cm. They indicated that when the incident occurred they were told by the DONS to assess the windows on the unit that resident #001 resided, and determined that the metal lever could be pulled downward very easily, which enabled the window to be opened more than 15 cm. Maintenance #102 identified that they applied a metal mechanism attached to the frame of the tracking on all the windows of the unit that resident #001 resided, which prevented the windows from opening more than 9 cm. They identified that they were not told to assess or modify the other three units windows. They confirmed that all the windows did not have the metal mechanisms on those three floors, and therefore could be opened more than 15 cm.

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The severity of this issue was determined to be a level three, as there was actual harm/actual risk. The scope of the issue was a level three, as the number of windows opening more than 15 cm was widespread. The home had a level two compliance history with no related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10. (692)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

Service Area Office /
Bureau régional de services : Sudbury Service Area Office