

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
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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 18, 2019	2019_745690_0017	013592-19	Follow up

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

TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 17, 2019.

The following intake was completed in this follow up inspection:

-One log, that was related to compliance order #001 from inspection report #2019_746692_0017, where the home was ordered to comply with section 16 of the Long-Term Care Homes Act, 2007, related to ensuring that no window in the home that opens to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres, with a compliance due date of July 15, 2019.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Nursing Services (DONS), Assistant Director of Nursing Services (ADONS), Director of Operations, Environmental Services Manager, Maintenance workers and Housekeepers.

The Inspector also conducted a tour of resident care areas, observed windows in the home, and reviewed internal documents.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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).

During inspection #2019_746692_0017, CO #001 was issued to the home, which ordered the licensee to;

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.

The compliance due date of this order was July 15, 2019.

Inspector #690 requested a copy of the audit that the home conducted to ensure that no window in the home that was accessible to residents could be opened more than 15 cm and was equipped with a screen. The home did not provide the Inspector with a copy of an audit.

Inspector #690 conducted an observation of the windows on the resident units and identified that windows in three identified resident rooms had a small screw installed in the track of the window frame and a metal lever attached to the window frame that when pulled downward allowed the window to open to 33 cm. Additionally, Inspector #690 identified that windows at either end of the resident hallways on the fifth floor, also had a small screw installed in the track of the window frame, and a metal lever attached to the window frame that when pulled downward allowed the windows in both hallways to open to 42 cm. Inspector #690 further identified that the window in an identified resident room and a window at the end of the resident hallway on the fourth floor had missing screens.

In an interview with Maintenance worker #105, they indicated that they had completed the audit on all the windows in the home that were accessible to residents, that they installed a larger screw on all the window frames that had small screws, and that they had tested each window afterwards to ensure it did not open more than 15 cm. Maintenance worker #105 indicated that they could not say which windows had larger screws installed on them and that they did not keep a record of the window checks.

In an interview with the Director of Nursing Services (DONS), they indicated that they

were aware that the home was to complete an audit of all windows in resident accessible areas to ensure that no window could open more than 15 cm and that the home was to keep a record of the audit, including any discrepancies and any follow up that was done to the windows. The DONS indicated to Inspector #690 that the home did have Maintenance worker #105 check all the windows and that they were told that Maintenance worker #105 had installed bigger screws in all the window frames that had small screws in them to prevent them from opening more than 15 cm and therefore did not think that they needed a record of which windows were fixed. The DONS indicated that the home should have kept a record of the audit that was completed by Maintenance worker #105 and that the audit should have identified the windows that the Inspector had observed to open more than 15 cm so the home could have addressed the issue.

In an interview with Inspector #690, the Chief Executive Officer (CEO) indicated that the home did complete an audit of the windows in the home, but that there were no records kept of the audit. The CEO further identified that the windows in the four identified resident rooms as well as the windows in the fourth and fifth floor hallways were not in compliance with the legislation as they opened more than 15 cm or were missing screens. The CEO acknowledged that the previous compliance order that was issued, ordered the home to ensure that no window in a resident area opened more than 15 cm and was equipped with a screen. The CEO further acknowledged that the home was to conduct an audit and keep records of the audit by the compliance due date of July 15, 2019, and that the home did not have records of an audit and that there were still windows that were missing screens or that could open to more than 15 cm. [s. 16.]

Additional Required Actions:

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

Issued on this 19th day of July, 2019

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) : TRACY MUCHMAKER (690)

Inspection No. /

No de l'inspection : 2019_745690_0017

Log No. /

No de registre : 013592-19

Type of Inspection /

Genre d'inspection: Follow up

Report Date(s) /

Date(s) du Rapport : Jul 18, 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(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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

Order # /**Ordre no :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Linked to Existing Order /** 2019_746692_0017, CO #001;
Lien vers ordre existant:**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. Specifically the licensee must:

- a) Conduct an audit on every window that opens to the outside and is accessible to residents to ensure that no window can be opened more than 15 centimetres and is equipped with a screen.
- b) Maintain a record of the results of the audit including documentation of the windows that were audited, the deficiencies that were found, follow up that was done to correct the deficiency and the final 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 (cm) centimetres.

During inspection #2019_746692_0017, CO #001 was issued to the home, which ordered the licensee to;

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.

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

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

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

The compliance due date of this order was July 15, 2019.

Inspector #690 requested a copy of the audit that the home conducted to ensure that no window in the home that was accessible to residents could be opened more than 15 cm and was equipped with a screen. The home did not provide the Inspector with a copy of an audit.

Inspector #690 conducted an observation of the windows on the resident units and identified that windows in three identified resident rooms had a small screw installed in the track of the window frame and a metal lever attached to the window frame that when pulled downward allowed the window to open to 33 cm. Additionally, Inspector #690 identified that windows at either end of the resident hallways on the fifth floor, also had a small screw installed in the track of the window frame, and a metal lever attached to the window frame that when pulled downward allowed the windows in both hallways to open to 42 cm. Inspector #690 further identified that the window in an identified resident room and a window at the end of the resident hallway on the fourth floor had missing screens.

In an interview with Maintenance worker #105, they indicated that they had completed the audit on all the windows in the home that were accessible to residents, that they installed a larger screw on all the window frames that had small screws, and that they had tested each window afterwards to ensure it did not open more than 15 cm. Maintenance worker #105 indicated that they could not say which windows had larger screws installed on them and that they did not keep a record of the window checks.

In an interview with the Director of Nursing Services (DONS), they indicated that they were aware that the home was to complete an audit of all windows in resident accessible areas to ensure that no window could open more than 15 cm and that the home was to keep a record of the audit, including any discrepancies and any follow up that was done to the windows. The DONS indicated to Inspector #690 that the home did have Maintenance worker #105 check all the windows and that they were told that Maintenance worker #105 had installed

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bigger screws in all the window frames that had small screws in them to prevent them from opening more than 15 cm and therefore did not think that they needed a record of which windows were fixed. The DONS indicated that the home should have kept a record of the audit that was completed by Maintenance worker #105 and that the audit should have identified the windows that the Inspector had observed to open more than 15 cm so the home could have addressed the issue.

In an interview with Inspector #690, the Chief Executive Officer (CEO) indicated that the home did complete an audit of the windows in the home, but that there were no records kept of the audit. The CEO further identified that the windows in the four identified resident rooms as well as the windows in the fourth and fifth floor hallways were not in compliance with the legislation as they opened more than 15 cm or were missing screens. The CEO acknowledged that the previous compliance order that was issued, ordered the home to ensure that no window in a resident area opened more than 15 cm and was equipped with a screen. The CEO further acknowledged that the home was to conduct an audit and keep records of the audit by the compliance due date of July 15, 2019, and that the home did not have records of an audit and that there were still windows that were missing screens or that could open to more than 15 cm.

The severity of the issue was determined to be a level three as there was actual risk. The scope was isolated. The home had a level 4 compliance history, with ongoing noncompliance with a compliance order issued in the last 36 months within this section of the LTCHA 2007, that included;
 -one compliance order issued July 8, 2019 (2019_746692_00017) with a compliance due date of July 15, 2019. (692)
 (690)

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

Jul 26, 2019

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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.

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Ordre(s) de l'inspecteur

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

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

**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

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.
O. 2007, chap. 8

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 révision
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 18th day of July, 2019

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Tracy Muchmaker

Service Area Office /

Bureau régional de services : Sudbury Service Area Office