Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 12, 2023

Inspection Number: 2023-1398-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Victoria Village Inc.

Long Term Care Home and City: Victoria Village Manor, Barrie

Lead Inspector	**Inspector Digital Signature**
Yami Salam (000688)	Yami Salam Digitally signed by Yami Salam Date: 2023.09.15 08:48:13 -04'00'

Additional Inspector(s)
Kim Byberg (729)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29-31, 2023 and September 1, 5-6, 2023
The inspection occurred offsite on the following date(s): September 1, 5, 7, 2023

The following intake(s) were inspected:
- Intake: #00089543 - Staff to resident improper care
- Intake: #00089744 - Complaint regarding resident care
- Intake: #00094315 - Fall Prevention and Management

The following intake(s) were completed in this inspection:

Intake #00085430, intake #00085603 and intake #00089418 were related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The Licensee failed to ensure that a resident was provided care as outlined in their plan of care.

Rationale and Summary

A resident was not provided a specific type of care on several occasions.

A Registered Practical Nurse (RPN) stated they did not provide an alternative when the care was not provided as outlined in the resident's plan of care.

The resident's quality of life may have been negatively impacted when the care was not provided on several occasions.

Sources: Review of the resident's medical records, interview with the resident's family, PSW, RPN and Director of Nursing. [729]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

The licensee has failed to ensure the home was equipped with a resident-staff communication and response system that could be used by a resident.

Rationale and Summary

A resident utilized a specialized communication system that was individualized for them.
In order for the resident to continue to use and activate the system, the staff member must reset the device each time after responding.

On a specific day, the resident told a PSW that their communication system was not working.

The PSW stated that the device had not been reset after it was activated from the previous day.

The Director of Nursing (DON) acknowledged that a new communication system had been implemented, and not all staff had been trained to reset the device after the call was answered.

The resident was at risk when they were not able to use their communication system when they required assistance.

Sources: Review of the home's communication response system, resident's medical records, interview with the resident's family member, PSW, DON, and maintenance staff member. [729]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure a resident received weekly skin and wound assessments for an area of altered skin integrity.

Rationale and Summary

A resident had an area of altered skin integrity.

An initial Skin Wound Care Assessment was completed, but no subsequent assessments were completed to monitor the area.

A Registered Practical Nurse (RPN) acknowledged that no Skin Wound Care Assessment was completed after the initial assessment. The Skin and Wound lead and Director of Nursing confirmed that a Skin and Wound Care Assessment should have been completed.

Failure to complete resident's skin integrity assessments at least weekly may have impacted decisions made related to treatment.

Sources: Resident's medical records, interview with RPN, Skin and Wound Care Lead and Director of Nursing. [000688]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The Licensee failed to ensure that a physician order was administered for a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

An order was not followed as prescribed by a physician for a resident.

Registered Practical Nurse (RPN) confirmed that the order was not administered as prescribed.

The resident was at risk of complications when they did not receive the prescribed order.

Sources: Resident's medical record, home's investigation notes, Interview with PSW, RPN and Director of Nursing (DON). [729]