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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: November 28, 2024

Inspection Number: 2024-1398-0004

Inspection Type:
Critical Incident
Follow up

Licensee: Victoria Village Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 7, 8, 12 - 14, 19 - 21, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00126262 - Follow-up #: 1 - CO #001/2024-1398-0003, FLTCA, 2021 - s. 24 (1), related to duty to protect, CDD October 4, 2024
- Intake: #00127111 - Intake: #00127997, and Intake: #00128183, related to allegations of resident abuse.
- Intake: #00125777, related to a respiratory outbreak.

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

- Intake: #00128495, related to a respiratory outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1398-0003 related to FLTCA, 2021, s. 24 (1)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)
Plan of care
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
(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.

The licensee failed to ensure that the staff and others involved in different aspects of care for a resident collaborated with each other in their assessments, 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.

Summary and Rationale

A resident was admitted to the home and their admission referral from Home and Community Care Support Services (HCCSS) stated situations of significant risk.

The home's Nurse Practitioner (NP) was aware of the risk and documented the risk in their admission assessment.

The home's Social Worker (SW) completed an admission assessment seven days after the NP, and did not assess or include the risks in their assessment. Their goal was to offer social work intervention as the resident transitioned into long-term care.

The resident's plan of care did not include any documentation, interventions, monitoring, or goals of care for the resident related to the risks identified by HCCS or the NP.

The home's SW and primary personal support worker (PSW) stated they were not aware of the resident's history of significant risk.

When the home's circle of care staff were not aware of a history significant risk, their assessments were not consistent, did not compliment each other, and as a result, the resident's plan of care was not developed fully, and interventions, monitoring and goals of care to safe guard and support them, were not put in place.

Sources: review of care plan, progress notes, HCCSS referral, social work assessment, NP medical assessment, interview with a PSW, NP, and Social Worker.

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from emotional abuse by a visitor.

For the purpose of this Act and Regulation, "emotional abuse" means: any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident

Summary and Rationale
A Registered Nurse (RN) overhead a visitor talking negatively to a resident and the RN felt the interaction was abusive and controlling towards the resident.

When the incident was reported to Director of Nursing (DON), they did not immediately follow up and no interventions were put in place to safe guard the resident.

The home has failed to protect the resident when they had previous knowledge of allegations of abuse of the resident. They did not take steps to ensure the resident's safety from admission to present. The home notified the police; however, did not put interventions in place after the incident to ensure the resident was safe.

Sources: Review of progress notes, care plan, home and community care referral, social work and Nurse Practitioner (NP) assessment, home investigation notes, interview with RN, Police officer and DON.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of a resident was complied with.

Summary and Rationale
An allegation of verbal abuse was reported to the DON.

The home failed to comply with the processes in their policies titled "Abuse & Neglect of a Resident – Actual or Suspected, and their Checklist for Investigation Alleged Abuse.

The home's checklist for investigation alleged abuse directed staff on what to do immediately, and within twenty-four hours when there was a suspicion of resident abuse.

The home did not follow their Abuse and Neglect policy or utilize the checklist to guide them through the steps to investigate. Additionally, the resident was not immediately removed from the situation or assessed after the interaction which put them at further risk of ongoing abuse.

Sources: Review of progress notes, home's investigation notes, policies titled

"Abuse & Neglect of a Resident – Actual or Suspected POLICY #: VII-G-10.0, current revision October 2019, and Abuse or Suspected Abuse of a Resident – Checklist for Investigating Alleged Abuse, Policy #VII-G-10.00(b) dated: May 2024, interview with RN, RPN, NP, PSW's and DON.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;

The licensee failed to ensure that when an allegation of abuse towards a resident was reported, that the home investigated the allegation immediately.

Summary and Rationale
An allegation of abuse towards a resident was reported to the DON.

The DON did not immediately investigate the allegation or take any action to safeguard the resident until the following day when they called the police.

When the home did not immediately investigate the allegation and take action, the resident was put at greater risk of the abuse continuing.

Sources: home's investigation notes, interview with RN, NP and DON

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that incidents of resident abuse were reported to the Director.

Rationale and Summary
A) A resident to resident altercation occurred causing injury to one of the residents. The critical incident (CI) report was not submitted to the Director until the following day.

Sources: CI Report, progress notes, interview with BSM.

Summary and Rationale
B) An allegation of verbal abuse towards a resident occurred.

The RN reported to the DON immediately; however, the DON did not report to the Director at the MLTC until the next day.

By not reporting allegations of resident abuse immediately to the Director put residents at risk when the Director was not able to provide follow up to the allegation in a timely manner.

Sources: Review of CI, progress notes, email from RN, interview with RN and DON.

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to complete assessments and re-assessments of a resident when they were involved in an altercation with a co-resident.

Summary and Rationale
An altercation occurred between two residents. One resident was injured in the altercation.

The home's NP increased their medications and ordered dementia observation screening (DOS) to be completed for seven days.

The home did not complete any DOS documentation or re-evaluate the resident's response to the increase in medication.

The Resident may have been at risk for delayed treatment and appropriate interventions when assessments and re-evaluations were not completed.

Sources: review of NP prescribed order for the resident, progress notes, home's policy titled "Dementia Observation System (DOS) policy #VII-F-10.02", interview with RN and responsive behaviour lead.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

The licensee failed to identify triggers that could potentially minimize the risk of altercations and potentially harmful interactions between residents.

Summary and Rationale
Two residents were observed by staff to have a physical and verbal altercation.

Three weeks later the residents had another altercation and due to the physical response a resident suffered an injury.

The RN stated that one of the residents was a trigger for the other resident.

The Resident's plan of care did not include any responsive behaviour triggers specific to co-residents, or include interventions to manage the triggers identified.

The Resident was at ongoing risk for altercations with a co-resident when triggers were not identified, and behavioural interventions put in place to manage the identified triggers.

Sources: Plan of Care for residents, progress notes, and interview with the RN.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that the home implemented one-to-one interventions for resident as recommended.

Rationale and Summary
A resident was physically aggressive towards another resident. 1:1 monitoring was recommended for the aggressive resident.

1:1 was not implemented and the resident continued to have multiple incidents of physical aggression towards co-residents.

Behavioural Support Manager, (BSM) considered the resident to be at high risk of responsive behaviours, and stated that the implementation of one-to-one interventions may have decreased the impact of physical aggression towards co-residents.

Sources: Progress note, secure conversation, interview with BSM.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Standard issued by the Director with respect to infection prevention and control (IPAC), was implemented.

Rationale and Summary

A) According to the IPAC Standard for LTCH's dated April 2022, revised September 2023, section 9.1 d) The licensee shall ensure that Routine Practices are followed, including proper use of PPE, including appropriate selection, application, removal, and disposal.

During the inspection, dietary staff were observed inappropriately using PPE, specifically gloves when they were serving food to residents.

The LTCH's Use of Gloves- Dietary, stated that gloves should only be worn for contact with large quantities of food when bulk mixing.

The Food Service Manager (FSM) acknowledged that dietary staff should not be wearing gloves to touch the MealSuite screen and then proceed to handle food.

By inappropriately wearing PPE, the staff increased the risk for the spread of food borne illness.

Sources: Interview with FSM, Use of Gloves Policy- Dietary XI-J-60.00 revised November 2021, and meal service observations during the inspection.

Rationale and Summary
B) According to the IPAC Standard for LTCHs dated April 2022, revised September 2023, section 5.6 references Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, section 5.5.1 Chemical Safety, recommendation to not apply cleaning chemicals by aerosol or trigger sprays.

During the inspection, a housekeeper was observed using an "Oxivir Tb" bottle with a trigger spray. The housekeeper was observed using the trigger spray while cleaning a resident's room.

The Director of Operations and IPAC Lead both stated that staff have the option to use the trigger spray bottles when cleaning.

By not following the Best Practice Recommendations, there was potential for the spread of infection.

Sources: Housekeeper observations, Interviews with Director of Operations, IPAC Lead, and Housekeeper, Best Practices for Environmental Cleaning for Prevention

and Control of Infections in All Health Care Settings, 3rd Edition dated April 2018, IPAC Standard for Long-Term Care Homes.

WRITTEN NOTIFICATION: CMOH and MOH

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Rationale and Summary
In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, 2024, effective October 2024, section 3.12 Enhanced Environmental Cleaning and Disinfection, the licensee shall clean and disinfect common areas minimum twice daily during an outbreak.

A COVID-19 outbreak was declared at the home that impacted three resident home areas. The housekeepers cleaning schedule did not indicate that common areas were to be cleaned twice daily during the outbreak.

A Housekeeper stated that there was no additional cleaning that took place during the outbreak. The IPAC Lead and Director of Operations indicated that the home

does not always complete high touch cleaning twice a day when in outbreak.

By not completing the high touch cleaning twice a day during the outbreak, there was risk for the spread of infection.

Sources: Housekeeper cleaning schedule, Interviews with Housekeepers, IPAC Lead, and Director of Operations, CIS Report

COMPLIANCE ORDER CO #001 Housekeeping

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that:

A) Complete monthly facility wide environmental audits to ensure that all chemicals used to clean/disinfect high touch surfaces are in their original labelled bottles or, if diluted, the bottles are properly labelled with the associated Material Safety Data Sheet (MSDS) label. The audits must be documented and include the date the audit was completed, the person completing the audit, the location of the unit audited,

type of chemical audited, expiry date, contact time of disinfection, and action plan if deficiencies are identified. The audits are to be completed ongoing and to be part of the home's IPAC strategy.

B) Complete weekly audits of all housekeeping staff to ensure proper technique, choice of appropriate chemical and cloth are used when cleaning high touch surfaces. The audits must be documented and include the date the audits are completed, the person completing the audit, the housekeeper's name being audited, the unit audited, the chemical used, the method of cleaning used, and action taken if deficiencies are identified. The audits are to be completed for two months or longer if deficiencies are identified.

C) Educate all housekeeping staff on the proper use of cleaning/disinfecting technique that includes when to use a spray bottle vs. moistened cloth to clean/disinfect high touch surfaces as per best practice guidelines, and how to read MSDS labels and follow appropriate contact time when cleaning/disinfecting. A knowledge test must be completed by each housekeeping staff to ensure understanding of material being taught. A copy of the education provided must include the date, person responsible for education, staff educated, educational material provided, scored knowledge test and signature of staff completing the education. A copy of the education must be kept in the home.

Grounds

The licensee failed to ensure that staff are cleaning and disinfecting contact surfaces in accordance with manufacturer's specifications.

Rationale and Summary

During the inspection, a housekeeper was observed using a bottle of Oxivir Tb to clean a resident's room. The housekeeper was observed spraying the Oxivir on the

windowsills and door handles, and then immediately wiping away the disinfectant.

A Housekeeper confirmed they filled Oxivir Tb bottles with Oxivir Plus, and did not follow the contact time required for the solution that was being used.

By not adhering to the manufacturer's specifications for the disinfection contact time it increased the risk of spreading infection.

Sources: Observation of a housekeeper, interview with a housekeeper, email from Director of Operations, pictures of Oxivir Plus bottle

This order must be complied with by January 13, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.

(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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