The Corporation of the City of Kawartha Lakes
Agenda
Victoria Manor Committee of Management Meeting

VMC2021-003
Monday, May 17, 2021
Meeting Commencing at 1:00 PM - Electronic Participation Only
Victoria Manor Boardroom
Victoria Manor, Second Floor
220 Angeline Street South, Lindsay, Ontario

Members:

Deputy Mayor Patrick O'Reilly
Councillor Doug Elmslie
Councillor Kathleen Seymour-Fagan

This will be an electronic participation meeting and public access to Victoria Manor Boardroom will not be available. If you wish to view the proceedings of this meeting please email Holly Russett at hrussett@kawarthalakes.ca to request electronic access through a Zoom invitation.
Accessible formats and communication supports are available upon request. The City of Kawartha Lakes is committed to accessibility for persons with disabilities. Please contact AgendaItems@kawarthalakes.ca if you have an accessible accommodation request.

		Pages
1.	Call to Order	
2.	Adoption of Agenda	
3.	Disclosures of Pecuniary Interest	
4.	Deputations and Presentations	
5.	Approval of the Minutes of the Previous Meeting	
5.1.	Minutes, Victoria Manor Committee of Management, March 15, 2021	3 - 7
6.	Business Arising from Previous Meetings	
7.	Correspondence	
8.	Reports	
8.1.	Memorandum 003 - Ontario Long-Term Care COVID-19 Commission Report	8 - 8
8.2.	Memorandum 004 - Ministry of Health and Long-Term Care Critical Incident Inspections	9 - 31
8.3.	Victoria Manor Operations Report to Committee of Management, March and April 2021	32 - 39
9.	Closed Session	
9.1.	Closed Minutes, Victoria Manor Committee of Management, March 15, 2021, Municipal Act, 2001 s.239(2)(b)(d)(g)	
9.2.	Victoria Manor Confidential Operations Report to Committee of Management, March and April 2021, Municipal Act, 2001 s.239(2)(b)(d)(e)	
10.	Matters from Closed Session	
11.	Other New Business	
12.	Next Meeting	
	July 19, 2021, Victoria Manor Boardroom, commencing at 1:00 p.m.	
13.	Adjournment	

The Corporation of the City of Kawartha Lakes

Minutes

Victoria Manor Committee of Management Meeting

VMC2021-002
Monday, March 15, 2021
1:00 P.M.
Electronic Video Meeting

Members:
Deputy Mayor Patrick O'Reilly
Councillor Doug Elmslie
Councillor Kathleen Seymour-Fagan

Accessible formats and communication supports are available upon request. The City of Kawartha Lakes is committed to accessibility for persons with disabilities. Please contact AgendaItems@kawarthalakes.ca if you have an accessible accommodation request.

1. Call to Order

Councillor Elmslie called the meeting to order at 1:03 p.m. Councillor K. Seymour-Fagan and Deputy Mayor P. O'Reilly were in attendance.

Executive Director Pamela Kulas, Director Rod Sutherland and Executive Assistant Holly Russett were also in attendance.

Regrets: Sienna Senior Living VP Operations and Long-Term Care Jennifer Powley

2. Adoption of Agenda

VMCM2021-014
Moved By Councillor Seymour-Fagan
Seconded By Deputy Mayor O'Reilly

That the agenda be adopted as circulated.

Carried

3. Disclosures of Pecuniary Interest

There were no declarations of pecuniary interest disclosed.

4. Deputations and Presentations

None

5. Approval of the Minutes of the Previous Meeting

VMCM20321-015
Moved By Deputy Mayor O'Reilly
Seconded By Councillor Seymour-Fagan

That the minutes of the Victoria Manor Committee of Management meeting held on January 18, 2021, be adopted as circulated.

Carried

6. Business Arising from Previous Meetings

None

7. Correspondence

None

8. Reports

8.1 Victoria Manor Operations Report to Committee of Management, January and February 2021

VMCM2021-016
Moved By Councillor Seymour-Fagan
Seconded By Deputy Mayor O'Reilly

That the Victoria Manor Operations Report to Committee of Management, January and February 2021, provided by Sienna Senior Living, be received for information.

Carried

8.2 Report VMC2021-02 2020 Victoria Manor Resident Satisfaction Survey

VMCM2021-017
Moved By Councillor Seymour-Fagan
Seconded By Deputy Mayor O'Reilly

Resolved That Report VMC2021-02, “2020 Victoria Manor Resident Satisfaction Survey”, be received.

Carried

8.3 Report VMC2021-03 2020 Victoria Manor Family Satisfaction Survey

VMCM2021-018
Moved By Deputy Mayor O'Reilly
Seconded By Councillor Seymour-Fagan

Resolved That Report VMC2021-03, “2020 Victoria Manor Family Satisfaction Survey”, be received.

Carried

9. Closed Session

VMCM2021-019
Moved By Deputy Mayor O'Reilly
Seconded By Councillor Seymour-Fagan

That the Victoria Manor Committee of Management convene into closed session in order to consider matters on the Monday, March 15, 2021 Closed Session Agenda and that are permitted to be discussed in a session closed to the public pursuant to Section 239(2)(b)(d)(g)(e) of the Municipal Act, S.O. 2001. S.25

Carried

10. Matters from Closed Session

The Closed Minutes of the Victoria Manor Committee of Management, January 18, 2021 meeting and Victoria Manor Confidential Operations Report to Committee of Management, January and February 2021 were received in Closed Session.

11. Other New Business

Letter to All Victoria Manor Staff from Victoria Manor Committee of Management

VMCM2021-023
Moved By Councillor Seymour-Fagan
Seconded By Deputy Mayor O'Reilly

That the letter drafted by Director Sutherland on behalf of the Victoria Manor Committee of Management to all Victoria Manor Staff in appreciation of all their dedication and hard work be distributed.

Carried

12. Next Meeting

May 17, 2021, Victoria Manor Boardroom, commencing at 1:00 p.m.

13. Adjournment

VMCM2021-024
Moved By Deputy Mayor O'Reilly
Seconded By Councillor Seymour-Fagan

That the Victoria Manor Committee of Management Meeting adjourn at 1:48 p.m.

Carried

Memorandum - 003

Date: May 17, 2021
To: Victoria Manor Committee of Management
From: Rod Sutherland, Director of Human Services
Re: Ontario Long-Term Care COVID-19 Commission Report

Recommendation

That the Memorandum regarding the Ontario's Long-Term Care COVID-19 Commission Report be received for information.

Rationale

The Province appointed the Commission on July 29, 2020 "to investigate the cause of the spread of the virus in long-term care and how it affected residents, staff, volunteers and family members" with a purpose "to shine a spotlight on this tragedy, to determine its causes and to make recommendations to help prevent the future spread of disease in long-term care homes".

On April 30, 2021 Ontario's Long Term Care COVID-19 Commission released its final report. The 322-page report, including its 85 recommendations, is available online at: https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf.

Staff will report back to the Committee as the Ministry of Long Term Care identifies their response to the report and their intentions.

Memorandum - 004

Date: May 17, 2021
To: Victoria Manor Committee of Management
From: Pamela Kulas, Executive Director
Re: Ministry of Health and Long-Term Care Critical Incident Inspections

A Ministry of Health Critical Incident Inspection was conducted on March 4-5 and March 10-11, 2021. During the inspection the following inspection protocols were used: Falls Prevention, Infection Prevention and Control, Minimizing of Restraining, Resident Charges, Safe and Secure Home.

During the course of the inspection the home received 5 Written Notices, 4 Voluntary Plan of Correction and 1 Compliance Order.

Glossary of Findings: In order of severity from lowest to highest

Finding Type	Short Form	Interpretation
Written Notice	WN	Evidence that not all information was found readily available as per the regulation
Voluntary Plan of Correction	VPC	It is recommended that a plan of action be put in place to ensure sustained follow up
Compliance Order	CO	The inspection found the regulation had not been followed
Directors Referral	DR	Sustained non compliance is found and the Director of the Performance, Compliance and Inspection Branch (MOHLTC) will review the Home's record
Work and Activity Order	WAO	Ministry staff will be on site regularly to ensure safe operations of the Home

To summarize findings:

1. **The licensee has failed to ensure that the home is safe and secure environment for its residents, related to the use of restraints**
    a. Corrective Actions:
        i. Falls lead (RPN) and Physiotherapy will re-assess each of the seven residents who currently have seatbelt applied.

ii. Physio will have supplier come into the home and complete an assessment to ensure that all residents who have seatbelts are applied appropriately.
iii. Restraints/PSAD assessments will be completed for all identified restraints in the home.
iv. Manufactures instructions to be obtained for all safety devices and will be available in falls program binder for all staff to have access
v. Education will be provided at registered staff meetings, PSW meetings and via learning packages on appropriate application and monitoring of the devices.
vi. Physiotherapist will work with nursing team to provide education.
vii. All residents will be reassessed at resident safety meeting and his plan of care will be based on his interdisciplinary assessment as it relates to seatbelts.
viii. Documentation of assessment to be completed via progress note through resident care plan.

2. The licensee has failed to ensure the falls prevention and management policy is in place.

a. Corrective Actions:

i. Education to registered staff regarding post fall assessment of resident i.e. injury.
ii. Re-education on falls prevention and management policy.

3. The licensee has failed to ensure the plan of care was based on an interdisciplinary assessment with respect to the resident safety risk for restraints.

a. Corrective Actions:

i. Residents restraint device has been reassessed.

4. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program related to aerosol generating medical procedures

a. Corrective Actions:

i. Education to registered staff regarding was completed and appropriate signage posted at the time of the visit.

5. **The licensee has failed to ensure that residents were not charged for goods and services that the licensee is required to provide**

    a. Corrective Actions:

        i. Residents were reimbursed for charges

Attachment A: MOHLTC Complaint Inspection Report 20210407

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 7, 2021	2021_643111_0005	017498-20, 019784-20, 021062-20, 002228-21	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Kawartha Lakes
26 Francis Streeet P.O. Box 9000 Lindsay ON K9V 5R8

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

Victoria Manor Home for the Aged
220 Angeline Street South Lindsay ON K9V 4R2

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

LYNDA BROWN (111)

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): March 4-5, 10-11, 2021

There were four critical incident reports(CIR) inspected concurrently during this inspection related to falls with injury for which the resident was taken to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers (HSK) and residents.

During the course of the inspection, the inspector: toured the home, reviewed resident health records, falls prevention committee meeting minutes, observed falls prevention equipment, observed a meal service, and reviewed the following policies: falls prevention management, Infection prevention and control (IPAC) and restraints/Personal Assistive Safety Devices (PASDs).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Resident Charges
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home is a safe and secure environment for its residents, related to the use of restraints.

Resident #003 sustained a fall with an injury and was transferred to hospital. The resident died in hospital a number of days later. From admission, to the time of their death, a number of months later, the resident had sustained a number of falls. The resident was using a restraining alarm device and had a number of near-miss incidents involving the device. After the first near-miss incident, the Physiotherapist (PT) contacted the supplier to have the device adjusted. After a number of incidents involving the device, the PT determined the restraining alarming device was a high-risk for injury to the resident and recommended the alarming device was replaced with a different alarming device. There was no indication the supplier was contacted at that time to have the restraining alarm device removed and a number of weeks later, the device was found in use again and the PT attached a note for staff not to use.

The PT indicated the alarming device for resident #003 had not been assessed for use as a restraint, despite the resident not being able to remove the device. The PT confirmed the device had not been applied correctly, they had no manufacturer's instruction for use and resulted in a number of high-risk, near miss incidents. Observation of resident #004 indicated the resident was using the same alarming device, the resident was not able to remove and had been applied incorrectly. The alarming device was not activated. Both nursing and physiotherapy staff were aware that the alarming device had not been applied correctly to both resident #003 and resident #004 and no immediate actions were taken to address the risk for injury. Resident #003 had a number of near-miss incidents involving the restraining device and the device remained on their mobility aid even after the decision was made to discontinue the device to address the risk for injury. Failing to ensure that restraining alarming devices are applied correctly or immediately discontinued when they are unable to be properly adjusted, and when there were incidents of high-risk for injury, results in an unsafe environment for the residents.

Sources: observation of resident #004, review of progress notes, restraint/PASD assessments, care plan for resident #003 and #004, manufacturer’s instructions for alarming device and interview of staff.

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the falls prevention and management policy was complied with for resident #001.

Resident #001 had sustained a fall and was assessed by an RPN. The resident complained of pain to a specified area (evidence of an injury) and was transferred back to bed with staff assistance. The resident continued to complain of pain to the same area, their condition had deteriorated and the RN notified the physician and Substitute Decision Maker (SDM), a number of hours later, when the resident was sent to hospital for assessment. The SDM expressed frustration that they were not informed of the fall until a number of hours later. The falls prevention policy indicated after a resident sustained a fall, the nurse was to ensure the resident was not moved if suspicion or evidence of injury, the physician contacted, arrange for immediate transfer to the hospital and the SDM notified. Failure to immediately notify the physician, SDM and transfer to hospital after the resident has a serious injury, could lead to further complications and prolonged pain.

Sources: CIR # M589-000025-20, progress notes and x-ray reports for resident #001, Falls Prevention and Management policy (revised February 2020) and interview with staff.

2. The licensee has failed to ensure that the falls prevention and management policy was complied with for resident #003.

Resident #004 had sustained a fall and was assessed by two RPNs.The resident complained of pain to a specified area and was assisted back to bed. A number of hours later, the resident continued to complain of pain with movement and was offered pain medication. The resident sustained a second fall a number of hours later, had visible injuries noted to specified areas and returned to bed with staff assistance. A number of hours later, the resident continued to complain of pain to the same area, had reduced range of motion (ROM), was transferred to hospital and died a number of days later. The falls prevention policy indicated after a resident sustained a fall, the nurse was to assess the resident for injury, limited range of motion, ensure the resident was not moved if suspicion or evidence of injury, the physician contacted and arrange for immediate transfer to the hospital. Failure to immediately notify the physician and transfer the resident to hospital after two falls with pain and suspected injury, lead to prolonged pain and possible further complications.

Sources: CIR, progress notes for resident #003, Falls Prevention and Management policy (revised February 2020) and interview with staff.

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to safety risks for resident #003 and #004.

Resident #003 had sustained a number of falls during a number of months, that they resided in the home. The last fall resulted in an injury for which the resident was transferred to hospital, diagnosed with a specified injury and died a number of days later. In addition, the assessments completed for resident #003 indicated the alarming device was assessed as a PASD, despite the resident being unable to remove the device. The resident had a number of near-miss, high-risk for injury incidents before the device was reassessed and replaced with a different alarming device. The resident was not offered additional fall protective equipment until after a number of falls and the recommended fall protective safety equipment had not been put in place until a number of weeks later. Resident #004 was also identified as using the same alarming device, but was assessed as a restraining device. An RPN confirmed awareness that resident #003 and #004 both used the same alarming device, but was unable to indicate why one resident's device was considered a PASD and the other was considered a restraint despite both resident's being unable to remove the device. Resident #004’s alarming device was also applied incorrectly. Nursing and physiotherapy staff failed to address or identify the safety risks in the plan of care related to the use of the restraining alarming device for both resident #003 and #004, and despite resident #003 having a number of near-miss incidents involving the use of the alarming device, before any actions were taken, placing them at risk for injury. Failing to ensure the plan of care is based on an interdisciplinary assessment that includes addressing the safety risks, placed resident #003 and #004 at risk for injury.

Sources: CIR, progress notes, restraint/PASD assessments and care plan of resident #003 and #004, observation of resident #004 and interviews with staff.

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 the plan of care is based on an interdisciplinary assessment with respect to the resident safety risks, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control (IPAC) program in the home related to use of AGMPs.

Observations by the Inspector on March 10 and 11, 2021 at various times, noted resident #005's room had an Aerosol Generating Medical Procedure (AGMP). There was no signage to indicate am AGMP was used, the risk of AGMPs and no personal protective equipment (PPE) available for staff use when entering the room. A PSW confirmed resident #005's AGMP was applied and removed at specified times by the PSWs and was unaware of IPAC procedures surrounding the use of the AGMP. The ADOC (IPAC lead) was aware of IPAC requirements with the use of AGMPs when the home was in outbreak, but was unaware of the IPAC procedures that were to be implemented on any resident with an AGMP, regardless of the outbreak status and based on the point of care risk assessment (PCRA). Failing to implement IPAC procedures around the use of an AGMP, poses a risk of infection to other residents and staff.

Resources: observations of resident #005, PRHC AGMP COVID-19 FAQs, COVID-19 Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 (dated March 30, 2020) and interview with staff.

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 all staff participate in the implementation of the infection prevention and control (IPAC) program in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

The licensee has failed to ensure that residents were not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network, related to safety devices.

During review of the progress notes for resident #003 for a critical incident related to falls, the Inspector noted that on a specified date, the Physiotherapist (PT) had contacted the Power of Attorney (POA), regarding the use of fall protective safety equipment and would have to be purchased by the family. The PT confirmed they were directed by the ADOC to have the families purchase the safety devices. The PT confirmed that resident #003's POA had purchased the safety equipment and they were aware of other current and deceased residents in the past yea who had also purchased the same equipment. The ADOC was unaware the home was to provide the safety equipment and the safety equipment had recently been purchased by the home for resident use. The Administrator indicated there were a number of residents identified as being charged for goods (safety equipment) and later verified that all of those residents, including resident #003, had been reimbursed for those charges as a result of the inspection.

Resources: progress notes of resident #003, billing invoices and interview of staff.

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 residents are not charged for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network., to be implemented voluntarily.

Issued on this 12th day of April, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2021_643111_0005
Log No. / No de registre :	017498-20, 019784-20, 021062-20, 002228-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 7, 2021
Licensee / Titulaire de permis :	The Corporation of the City of Kawartha Lakes 26 Francis Streeet, P.O. Box 9000, Lindsay, ON, K9V-5R8
LTC Home / Foyer de SLD :	Victoria Manor Home for the Aged 220 Angeline Street South, Lindsay, ON, K9V-4R2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Kulas

To The Corporation of the City of Kawartha Lakes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.5 and ensure that the home is a safe and secure environment for its residents.

Specifically, the licensee shall:
1. Reassess all residents in the home currently using seat belts or alarming seat belt devices to ensure the device is applied correctly.
2. Complete the restraint/PASD assessment tool for each of those same residents, to ensure they are correctly assessed for use as either a PASDs or restraint.
3. Ensure all safety devices, including seat belts and alarming seat belts have manufacturers instructions available for staff review.
4. Educate all nursing and physiotherapy staff on the correct use of all seat belt devices (including alarming devices) and keep a documented record, to ensure all staff are aware of the correct use of the devices and proper application.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents related to the use of restraints.

The licensee has failed to ensure that the home is a safe and secure environment for its residents, related to the use of restraints.

Resident #003 sustained a fall with an injury and was transferred to hospital. The resident died in hospital a number of days later. From admission, to the time of their death, a number of months later, the resident had sustained a number of falls. The resident was using a restraining alarm device and had a number of near-miss incidents involving the device. After the first near-miss incident, the

Physiotherapist (PT) contacted the supplier to have the device adjusted. After a number of incidents involving the device, the PT determined the restraining alarming device was a high-risk for injury to the resident and recommended the alarming device was replaced with a different alarming device. There was no indication the supplier was contacted at that time to have the restraining alarm device removed and a number of weeks later, the device was found in use again and the PT attached a note for staff not to use.

The PT indicated the alarming device for resident #003 had not been assessed for use as a restraint, despite the resident not being able to remove the device. The PT confirmed the device had not been applied correctly, they had no manufacturer's instruction for use and resulted in a number of high-risk, near miss incidents. Observation of resident #004 indicated the resident was using the same alarming device, the resident was not able to remove and had been applied incorrectly. The alarming device was not activated. Both nursing and physiotherapy staff were aware that the alarming device had not been applied correctly to both resident #003 and resident #004 and no immediate actions were taken to address the risk for injury. Resident #003 had a number of near-miss incidents involving the restraining device and the device remained on their mobility aid even after the decision was made to discontinue the device to address the risk for injury. Failing to ensure that restraining alarming devices are applied correctly or immediately discontinued when they are unable to be properly adjusted, and when there were incidents of high-risk for injury, results in an unsafe environment for the residents.

Sources: observation of resident #004, review of progress notes, restraint/PASD assessments, care plan for resident #003 and #004, manufacturer's instructions for alarm device and interview of staff.

An order was made by taking the following factors into account:
Severity: There was actual risk to the residents, as resident #003 had a number of near-miss incidents involving the improper use of the alarming device and resident #004 also had the same device improperly applied and no actions were taken.
Scope: This non-compliance was a pattern as two residents were determined to have the same device improperly applied.
Compliance History: The home has had previous non-compliance to different

subsections in the past 36 months.
(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 30, 2021

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 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 7th day of April, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office

March and April 2021 Victoria Manor Operations Report to Committee of Management

Submission Date: May 17, 2021

Information for the Months of: March and April 2021

Table 1: Victoria Manor Executive Summary Statement of Earnings for March 2021

	Year-to-Date Actual	Year-to-Date Budget	Year-to-Date Variance
Resident Days	12,325	14,716	(2,391)
Occupancy %	82.5%	98.5%	(16.0%)
Nursing Envelope Funds	1,687,326	1,724,694	(37,368)
Nursing Expenses	1,922,740	2,146,532	223,793
Net Nursing Envelope	235,413	421,838	186,424
Program Envelope Funds	180,994	180,995	(0)
Program Expenses	172,689	186,515	13,826
Net Program Envelope	8,305	5,521	13,826
Food Envelope Funds	142,528	142,528	-
Food Expenses	135,709	142,528	6,819
Net Food Envelope	6,819	-	6,819
Accommodation Revenue	1,016,758	1,046,875	30,118
Accommodation Expenses			
Dietary Expenses	300,115	322,515	22,399
Housekeeping Expenses	134,026	148,720	14,694
Laundry Expenses	57,343	59,008	1,665
Maintenance Expenses	97,787	171,837	74,050
Administration Expenses	115,067	149,847	34,780
Facility Expenses	290,250	281,936	(8,314)

	Year-to-Date Actual	Year-to-Date Budget	Year-to-Date Variance
Accommodation Expenses	994,587	1,133,863	139,276
Pandemic Revenue	556,898	-	556,898
Pandemic Expenses	497,274	29,589	467,685
Net Pandemic Expenses	59,624	29,589	89,213
Net Operating Income	145,314	543,935	398,621
Capital Reserve	37,869	-	37,869
Net Income (Loss)	183,183	543,935	360,752

Variance Explanations

Nursing Revenue: Year-to-Date (YTD) is is unfavorable ($37K) mainly due to lower BSO funding ($36K) and lower falls prevention ($1K).

Nursing Expenses – Direct: YTD expenses are favorable ($117K) mainly due to lower RN wages ($54K), lower RPN wages ($36K), lower BSO wages ($39K), lower agency wages ($8K), lower benefits ($23K), lower MDS RAI ($7K); offset by higher PSW wages ($51K).

Nursing Expenses – Administration: YTD expenses are favorable ($107K) mainly due to lower wages ($52K), lower benefits ($17K), lower MDS RAI ($4K), lower computer expenses ($3K), lower equipment expenses ($3K), lower medical supplies ($26K), lower incontinent supplies ($2K); offset by higher staff cost ($1K).

Program Revenue: YTD revenue is in line with budget.

Program Expenses: YTD expenses are favorable ($14K) mainly due to lower wages ($7K), lower benefits ($3K), lower IT allocations ($1K), lower physio ($1K), lower supplies ($2K), and lower transportation costs ($1K).

Food Revenue: YTD revenue is in line with budget.

Food Expenses: YTD expenses are favourable ($7K).

Accommodation Revenue: YTD revenue is unfavorable ($30K) mainly due to lower basic accommodation ($22K), lower preferred accommodation ($15K), lower other income

from hair care ($2K), lower prior period LTC reconciliation ($1K); offset by higher miscellaneous income from vendor rebates ($11K).

Pandemic Expenses: YTD expenses is favourable ($89K).

Dietary Expenses: YTD are favorable ($22K) mainly due to lower wages ($14K), lower benefits ($3K), lower equipment expenses ($4K), lower supplies ($2K); offset by higher dishes, cutlery & utensils ($1K), and lower recovered costs ($1K).

Housekeeping Expenses: YTD are favorable ($15K) mainly due to lower wages ($11K), lower benefits ($3K), lower chemical and cleaning supplies ($1K), lower equipment expenses ($4K); offset by higher supplies ($3K).

Laundry Expenses: YTD expenses are favorable ($2K) mainly due to lower bedding and linen ($3K), lower chemical and cleaning supplies ($1K), lower equipment expenses ($3K); offset by higher wages ($4K), and higher benefits ($1K).

Maintenance Expenses: YTD Maintenance expenses are favorable ($74K) mainly due to lower wages ($19K), lower benefits ($4K), lower alarm ($1K), lower building repair ($2K), lower electrical ($2K), lower minor capital funding ($37K), lower fire systems ($4K), lower generator ($3K), lower grease trap cleaning ($1K), lower heating and air-conditioning ($5K), lower plumbing ($1K), lower supplies ($1K), lower contracted services ($3K); offset by higher equipment expenses ($2K), and higher landscaping and snow removal ($7K).

Administration Expenses: YTD expenses are favorable ($35K) mainly due to lower wages ($13K), lower bad debts ($3K), lower computer expenses ($3K), lower software and software subscriptions ($17), lower postage and courier ($1K), lower professional fees ($4K), lower purchased services ($20K), lower supplies ($1K), lower travel ($1K); offset by higher benefits ($4K), higher communications expenses ($1K), higher office equipment expenses ($22K), and higher staff costs ($1K).

Facility Expenses: YTD expenses are unfavorable ($8K) mainly due to higher management fees ($13K), offset by lower gas ($1K), and lower hydro ($3K including $19K rebate).

Table 2: Year to Date Capital Expenses: March 2021

Capital Expense	Approved 2021 Budget	Year-to-Date Expenses
Wanderguard System	15,000	
Whirlpool Bath Tub	35,000	Received and installed

Capital Expense	Approved 2021 Budget	Year-to-Date Expenses
Portable Lifts (2)	30,000	Received and in use
Air conditioning cooling units in serveries	13,000	
Food Processor	6,000	
Hand held devices	944	
Repair and replacement of existing outdoor walkways	23,000	
Totals	122,944	

The whirlpool bath tubs and portable lifts were purchased utilizing Ministry of Health (MOH) 2020-21 Infection Prevention and Control (IPAC) Containment funding and the MOH IPAC Minor Capital revenue. As a direct result, $65,000 will not be not be charged to Victoria Manor's capital expense account.

A five (5) year, 2022-2027 capital plan is being developed for the home. As a result, all roof top units including air conditioning, air exchange and heating units have been inspected. It has been determined that the main air conditioning/heating unit installed in 1990 requires replacement this year under emergency expenditure. The approximate cost to replace the unit is $258,770.

For the 2021-22 funding year, the MOH under the IPAC Minor Capital has provided an additional $149,600 towards the eligible expense of air conditioning and roof top replacement.

To offset the $229,000 main air conditioning/ heating unit replacement cost, the 2021 capital savings of $65,000 and the IPAC minor capital funds of $149,600 will be utilized. In total, $44,170 will be required from the emergency funds.

Scorecard: Quality

Table 3: Canadian Institute for Health Information (CIHI) quarter 3 (October to December 2020) results.

Indicator	2020 Q3 Current Performance	Target
Antipsychotic medications	22.30	19.10
New Stage 2-4 pressure ulcers	1.70	2.00
Worsened stage 2-4 pressure ulcers	2.30	2.50
Has fallen	14.20	16.50
Daily physical restraints	3.30	2.90
Has pain	3.80	5.50
Worsened pain	5.10 *	9.40
Percentage of complaints received by a LTCH that were acknowledged to the individual who made a complaint within 10 business days.	100	100
Transfers to Emergency department (note Q1-Q4 2019)	24.6	29.70

* Better than Health Quality Ontario benchmark

Indicators are monitored monthly during Resident Safety meetings. Action plans are in place.

Scorecard: People

Employee Engagement

- Jean Pereira, Manager of Building Services commenced new role March 7, 2021
- 34 team members were recognized in March by residents and peers through the Spot A Star program.
- 21 team members were recognized in April by residents and peers through the Spot A Star program.

Sienna Support Services Updates

Sienna Partner Visits:

- Dietary Partner – March 30, 2021

- Building Partner – April 13, 2021
- Director of Long Term Care Systems – April 15, 2021
- IPAC Partner, Clinical Partner, Director of Clinical Services – April 30, 2021

Projects, Location Events and Other

- 2021 Operational Plan Developed and communicated

Long Term Care Update

Occupancy (data since last report)

- 82.5% occupancy
- 1 Discounted Private or Semi–private beds (under 60%)
- 13 move ins and 8 discharges

Regulatory visits i.e. MOL, Public Health

Ministry of Health Inspector completed visit focusing on critical incidents March 4-5, 10-11, 2021.

Written and Verbal Complaints Summary

Written complaint received from a family member who expressed concerns with co-residents entering residents room. Complaint resolved.

Written complaint received from a family member who had concerns about the staffing levels in Victoria House. Complaint resolved.

Written complaint received from a family member who felt that obtaining a urine specimen was not followed up in a timely manner. Family also expressed concern about a television remote control missing. Complaint resolved.

Written complaint received from a family member who was concerned about the follow up of a team member. Complaint resolved.

Compliments Summary

Many cards of thank you received from families for the wonderful care provided by team members.

Occupational Health and Safety Issues

Nothing to report

Resident and Family Satisfaction Survey

Results used to develop the 2021 Victoria Manor operating plan.

Virtual town hall held on March 31 and April 28.

Resident/Family Council Updates

Resident Council meetings held the 1st Thursday of each month. Family Council president hosts monthly virtual meetings the 1st Wednesday of each month.

Resident's Council and Family Council received a copy of the 2020 Program Evaluations.

Emergency Preparedness and Environmental concerns

Code Red drills were held on all three (3) shifts in March and April 2021.

Code Grey drill held on March 22, 2021.

Code Blue drill held on April 6, 2021.

Actual Code Red on March 22, 2021 at 10:45 pm when a make-up air unit transformer for the kitchen sparked creating black smoke to fill the kitchen. The Incident Management System (IMS) was initiated and 911 was called. Communication plan enacted accurately. There was no loss of services. Evaluation completed. Transformer replaced.