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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 21, 2021	2021_884647_0001	025952-20, 001372-21, 004087-21	Critical Incident System

Licensee/Titulaire de permis

Board of Management for the District of Parry Sound West
21 Belvedere Avenue Parry Sound ON P2A 2A2

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

Belvedere Heights
21 Belvedere Avenue Parry Sound ON P2A 2A2

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

JENNIFER BROWN (647)

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): April 12 - 15, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

-one log related to improper transfer of a resident,
-one log related to improper care, and
-one log related to staff to resident abuse.

Inspector #704609 had observed this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeepers, and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed Infection Control and Prevention (IPAC) practices, observed dining and snack service, observed medication administration, observed staff to resident interactions, resident to resident interactions, and the provisions of care, reviewed internal documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques, when staff assisted a resident; specific to using two staff.

The home submitted a Critical Incident System (CIS) report to the Director that indicated that a Registered staff member observed a resident being transferred by only one staff member.

The resident's plan of care at the time of the incident, indicated that the resident was required to have two people assist during any transfer process.

In an interview with the Administrator, they verified that the direct care staff member had unsafely transferred the resident from their bed as the direct care staff member did not have a second staff member present.

Sources: Observations of resident, record review, interviews with an RPN, and other staff members. [s. 36.]

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 staff use safe transferring and positioning devices or techniques, when staff assist resident #005; specific to using two staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

During the inspection, it was observed by the Inspector that a treatment cart was unlocked. The Inspector opened the top drawer and found one open ampule of an injectable medication, that contained half of its contents of medication.

An interview with a Registered Nurse indicated they were not aware how long the open ampule had been there or what resident it had been for, however, the RN indicated that medications were required to be secured at all times.

In an interview with the Administrator, they verified that all medications were required to be locked when not being administered.

Sources: Treatment cart, Observation of medication administration, related policies, interviews with an RN, and other staff members. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) program, was evaluated and updated at least annually in accordance with evidence-based practices and, if there was none, in accordance with prevailing practices, specifically to ensure there was signage posted on or near the entrance door of affected residents that indicated the resident was on additional precautions.

In accordance with Public Health Ontario, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, homes are required to have signage specific to the type(s) of additional precautions posted. A sign that lists the required precautions was to be posted at the entrance to the resident’s room or bed space.

During the inspection, the Inspector observed that two resident rooms, had a cart that contained additional Personal Protective Equipment (PPE) outside the resident’s door, however, no sign was present to indicate what the required PPE would be.

An RN indicated that staff and visitors would not be aware of what PPE they would be required to don to enter the residents room and further indicated all doors with affected resident's were required to have a sign to ensure all staff were aware of the additional precautions they must take to care for the affected resident.

Sources: Inspector #647's observations, Interviews with the Administrator and other staff, and Public Health Ontario, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012. [s. 229. (2) (d)]

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 the Infection Prevention and Control (IPAC) program, was evaluated and updated at least annually in accordance with evidence-based practices and, if there was none, in accordance with prevailing practices, specifically to ensure there is signage posted on or near the entrance door of affected residents that indicate the resident is on additional precautions, to be implemented voluntarily.

Issued on this 23rd day of April, 2021

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

Original report signed by the inspector.