Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 9, 2015	2015_288549_0027	O-002647-15	Resident Quality Inspection

Licensee/Titulaire de permis

VALLEY MANOR INC
88 Mintha Street P.O. Box 880 Barry's Bay ON K0J 1B0

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

VALLEY MANOR NURSING HOME
88 Mintha Street P. O. Box 880 Barry's Bay ON K0J 1B0

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

RENA BOWEN (549), ANANDRAJ NATARAJAN (573), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 28, 29, 30, October 1, 2, 5, 6, 7 ,8, 2015

The following Critical Incident Inspection Log# O-001988-15, O-002064-15, O-002597-15 and O-002709-15 were conducted at the same time as the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with several residents, family members, President and Vice President of Residents Council, Personal Support Workers (PSW), Dietary Aides (DA), the Behaviour Support Outreach Personal Support Worker (BSO), Restorative Care Workers, a Recreation Aide, Registered Practical Nurses (RPN), Registered Nurses (RN), the Human Resources Assistant, the Administrative Assistant, the Nursing Staffing Clerk, the Nursing and CQI Co-ordinator, the Support Services Manager (SSM), the Director of Care (DOC) and the Chief Executive Officer (CEO).

During the course of the inspection, the inspector(s)conducted a tour of the home, observed resident dining, resident care, staff and resident interactions, infection control practices and the medication administration, reviewed resident health care records and menus.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **7 WN(s)**
- **2 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	Legendé 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. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident bedroom occupied by more than one resident have sufficient privacy curtains to provide privacy.

The home has a combination of shared and private rooms in each of the home areas.

The following observations were made on October 6, 2015 by Inspector #549 with the Support Services Manager:

In two specific shared resident rooms, when the privacy curtain was fully drawn there was a gap of approximately 2 feet on the right side where there was no privacy curtain to provide sufficient privacy for the resident.

In two specific shared resident rooms, when the privacy curtain was fully drawn there was a gap of approximately 4 feet on the right side where there was no privacy curtain to provide sufficient privacy for either resident.

In a specific shared resident room , the privacy curtain cannot be fully drawn as there was a screw in the ceiling track preventing the curtain from being able to be fully drawn leaving a gap of approximately 3 feet on the left side where there was no privacy curtain to provide sufficient privacy for the resident.

On October 6, 2015, during the observations the Support Services Manager confirmed with Inspector #549 that the privacy curtains in the shared resident rooms observed on October 6, 2015 did not provide sufficient privacy for the residents.

The Support Services Manager indicated to Inspector #549 that all shared resident rooms privacy curtains would be audited for sufficient privacy for both residents when the privacy curtains are fully drawn. [s. 13.]

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 every resident bedroom occupied by more that one resident has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On September 29, 2015 Inspector #549 observed a wound on a specific body part on Resident #031 which appeared to have fresh blood in it.

The current plan of care indicates that the care treatment for the wound area is to keep a dry dressing on the specific body part as the resident will pick at the wound causing it to bleeding.

The Multidisciplinary Care Conference notes for a specific date in 2015, indicate that a specific treatment is not reasonable given the severity of the resident's dementia and the ongoing picking at the wound which has recently noted to be larger.

The resident's progress notes for a specific date in 2015 indicated that the wound area to the specific body part had increased in size. The resident was picking at the affected area. The affected area was bleeding, a dressing was applied twice and the resident had taken off the dressing once.

Inspector #549 reviewed Resident #031's health care file for a specific period in 2015 and was unable to locate a skin assessment that was completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

On October 5, 2015 during a discussion with the Director of Care and the Nursing and CQI Co-ordinator it was indicated to Inspector #549 that the home uses a clinically appropriate skin assessment instrument that is specifically designed for skin and wounds only when residents have pressure ulcers.

The DOC confirmed with Inspector #549 that residents exhibiting altered skin integrity, including skin breakdown, skin tears or wounds do not receive a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wounds. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a physical device is applied, that the device is ordered or approved by a physician or a registered nurse in the extended class.

On September 29, October 1, and October 6, 2015, Inspector #573 observed Resident # 006 lying in the bed with two ¾ bed rails in up position and with a posey padding.

On October 6, 2015 the inspector spoke with PSW S#112 who indicated that Resident #006 attempts to crawl out of the bed and the two ¾ bed rails and posey padding prevent the resident from falling out of the bed.

The inspector spoke with RPN S#113 who indicated Resident #006 moves around in the bed and the two ¾ bed rails and posey padding is used for resident safety and support in the bed.

Resident #006 current written plan of care was reviewed by Inspector #573 and under Risk for falls, it states "Put 2 side rails up at all times when in bed for Safety"

During an interview RN S#114 indicated to Inspector #573 that for Resident #006 they consider the use of two ¾ bed rails and the posey padding as a restraint for the safety of the resident. RN S#114 reviewed the resident's health care records in the presence of the inspector and confirmed that Resident #006 does not have an order from a physician or registered nurse in the extended class for the use of the two ¾ bed rails and the posey padding as a restraint. [s. 31. (2) 4.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

During an observation on September 29, October 2, and October 5, 2015 Inspector #573 observed Residents #007, #013 and #045 with long facial hair either visible under the chin, neck or along the jaw line.

The written plan of care in effect for all three residents indicates that each resident requires some level of assistance from the staff for daily personal hygiene and grooming. Further the plan of care for Residents #007 and #013 does not provide any direction for the provision of facial hair removal.

The inspector spoke to each resident and all three residents were able to answer questions about their facial hair and indicated that if offered to them, they would have the facial hair removed.

The inspector spoke with PSW S#105 and PSW S#106, both indicated Residents #007 and #013 require physical assistance from staff with daily personal care and grooming. Further the PSW staff stated that Resident #007 and Resident #013 did not have any behavioural concerns where staff would not be able to provide grooming including removal of the facial hair.

During an interview PSW S#117 indicated Resident #045 requires total assistance from staff with daily grooming and further indicated Resident #045 did not have any behavioural concerns where she would not be able to provide daily grooming.

On October 5, 2015 Nursing and CQI Co-ordinator S#102 observed all three residents in the presence of the Inspector #573 and confirmed that Resident #007, #013 and #045's facial hairs are long and are to be removed by the PSW staff. Nursing and CQI Co-ordinator S#102 further indicated that she will ensure that above residents' receive personal care and grooming on a regular basis. [s. 32.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

On September 29 and 30, 2015 Inspector #573 observed Resident #001 seated in a tilt wheelchair with a front closing lap belt and a lap tray in place. The inspector spoke to Resident #001 who stated that he/she is physically not capable to release the wheelchair lap belt or remove the lap tray.

On September 30, 2015 Inspector interviewed two PSW staff members in relation to Resident #001's wheelchair lap belt and tray. PSW S#107 indicated that Resident #001's wheelchair lap tray is used to assist the resident with specific tasks. PSW S#108 indicated to inspector that Resident #001's wheelchair lap belt helps to keep the resident safe in the wheelchair. Both the PSW staffs confirmed with the inspector that the resident is not able to release the seat belt or remove the lap tray.

On September 30, 2015 during an interview, RPN S#109 indicated that the wheelchair lap belt and lap tray were used for Resident #001 as personal assistance services device (PASD). RPN S#109 indicated that previously, Resident #001 was able to release both the lap belt and the tray but now, the resident is physically not able to release or remove the wheelchair lap belt and the lap tray.

Resident #001's current written plan of care was reviewed by the inspector and there was no information that indicates the resident requires the use of the wheelchair lap belt or lap tray as a PASD.

Inspector #573 spoke with RN S#110 who indicated that Resident #001's wheelchair lap belt and lap tray are used as a positioning device and PASD. RN S#110 further confirmed with the inspector that Resident #001 was not reassessed and the plan of care not updated for the use of wheelchair lap belt and lap tray as a PASD when the resident's care needs changed. [s. 33. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal.

Inspector #138 reviewed the posted weekly menu and noted that a slice of bread is to be offered at lunch and dinner. The inspector also cross referenced the therapeutic spreadsheet menu and noted that a slice of bread including texture modified bread was part of the planned menu. The inspector observed three lunch meal services and did not observe that a slice of bread was offered to residents during these meals. The inspector spoke with a PSW in the dining room during the third lunch service observation about bread and the PSW stated that she has never seen bread offered to residents at lunch. [s. 71. (4)]

WN #7: 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 the drugs are stored in an area or a medication cart that is exclusively for drugs and drug-related supplies.

Inspector #549 observed the noon hour resident medication administration pass on October 5, 2015.

During the observation it was noted by the inspector that the second drawer of the medication cart had a caddy full of dressing supplies for resident treatments.

There are three separate medication carts in use in the home. Each medication cart is for a specific resident home area. RPN S#103 confirmed at the time of the observation that the medication cart she was using held the dressing supplies for the residents in the home area assigned to her.

On October 6, 2015 RPN S#111 indicated that all three of the medication carts have a caddy stored in the second draw with dressing supplies in it.

On October 7, 2015 during an interview the DOC confirmed with inspector #549 that all three medication carts have a dressing caddy in the second draw which contains dressing supplies such as 2x2s, 4x4s, gauze, tape, scissors, tegaderm, telfa and opsite which are used by the registered staff for resident treatments. The DOC indicated to the inspector that the non drug-related supplies would no longer be stored in the medication carts. [s. 129. (1) (a)]

Issued on this 9th day of October, 2015

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

Original report signed by the inspector.