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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: June 4, 2025
Inspection Number: 2025-1180-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Valley Manor Inc.
Long Term Care Home and City: Valley Manor Nursing Home, Barrys Bay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 20, 21, 22, 23, 26, 27, 28, 29, 30, 2025

The following intake(s) were inspected:

- Intake: #00147671 - PCI

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's written plan of care was updated when they no longer required treatment for a wound that resolved on a specified date in March 2025. The licensee updated the care plan on a specified date in May 2025 to remove the focus and interventions regarding the wound.

Sources: A resident's clinical record, and interview with an RPN.

Date Remedy Implemented: May 29, 2025

WRITTEN NOTIFICATION: Skin and Wound

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

1) The licensee has failed to ensure that a resident be reassessed weekly for their wound, using a clinically appropriate skin assessment tool. Specifically, a resident did not have a skin assessment completed on specified dates in February and March, 2025, which were the skin assessments scheduled for those weeks.

Sources: A resident's clinical chart, interview with an RPN and the Skin and wound Lead.

2) The licensee has failed to ensure that a resident be reassessed weekly for their their wounds, using a clinically appropriate skin assessment tool. Specifically, a resident did not have any skin assessments, utilizing the homes skin assessment tool, completed after a specified date in May 2025.

Sources: A resident's clinical record, interview with an RPN and the Skin and wound lead.

WRITTEN NOTIFICATION: Annual Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (1)
Retraining
s. 260 (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The licensee has failed to ensure that all staff receive annual IPAC training in accordance with O.Reg 246/22 s. 259 (2) c, d, and h. Specifically, a PSW and an RPN were not provided with IPAC training in 2024 with respect to respiratory etiquette, signs and symptoms of infectious diseases and handling and disposing of biological and clinical waste including personal protective equipment (PPE).

Sources: Training records for staff, the homes training PowerPoint, interview with IPAC lead and other staff.

COMPLIANCE ORDER CO #001 Doors in a home

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Ensure all utility doors located on resident hallways are in good working order to

ensure restricted unsupervised access by residents.
B) Conduct weekly audits of all utility doors on resident hallways for three consecutive weeks to ensure compliance.
C) Maintain a written record of audits; including the date, who completed the audits, results of the audits and any corrective actions taken.

Grounds

The licensee has failed to ensure multiple utility room doors in resident hallways are equipped with a lock to restrict unsupervised access by residents.

On a specified date in May, 2025, at a specified time, an inspector was able to open the utility room door on a resident hallway without entering a code into the key pad. Upon entry into the utility room inspector observed cleaning and disinfecting products.
Due to resident safety concerns inspector informed the Director of Care (DOC). The Director of Care confirmed the utility room door should only be able to be opened if the code is entered and stated they would inform the maintenance supervisor and the door would be repaired immediately.

On a specified time in May 2025, at a specified time, inspector went to test if the door of the soiled utility room door had been repaired, inspector attempted to open the utility room door in one of the resident hallways. Inspector was able to open the door without entering the code if the doorhandle was turned counterclockwise.

The inspector reinspected all the utility room doors, to ensure the doors remained securely locked when the handle was turned in both directions.

At a specified time, inspector found the utility room door on another resident hallway, was able to be opened without entering a code into the key pad. Inside the utility room inspector noted the oxygen refilling station, extra oxygen tanks, and

nursing supplies including boxes of syringes.

At another specified time, inspector opened an additional utility room door on a resident hallway without entering a code into the keypad. This utility room housed a nursing dressing cart which had bottles of wound cleaning solution on the top of the cart.

At a specified time, the inspector spoke to the Chief Executive Officer (CEO) to request immediate action be taken to ensure resident safety. After speaking with staff the CEO stated the doors would be fixed and this would be demonstrated to the inspector prior to the end of the day.

At a specified time, the maintenance manager informed an inspector, the identified utility room doors had been fixed. Accompanied by the maintenance manager, the inspector inspected the doors and found them to be locked and secured.

Sources: Inspector observations, interview with the Maintenance Manager, DOC and CEO.

This order must be complied with by July 11, 2025

COMPLIANCE ORDER CO #002 Air temperature

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Educate all registered staff on the procedure of monitoring and documenting the air temperatures and the required actions if the air temperatures in the home fall below 22 degrees Celsius.
B) Document the education provided including a description of the education provided, the name of the registered staff member receiving the education, the date the education was provided and who provided the education.
C) Conduct weekly audits of air temperatures logs for three consecutive weeks to ensure compliance with the procedure.
D) Take immediate corrective action if deviations from the procedure are identified.
E) Maintain a written record of everything required under this compliance order from A-D, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees.

A review of the air temperature logs from specified dates between March and May, 2025, revealed registered staff monitor and document the air temperatures in the home three times per day, in four common areas in the home and in two resident bedrooms. Between March to May 2025, the air temperature was monitored and documented at 21 degrees Celsius 59 times. The air temperature was monitored and documented at 20 degrees Celsius two times, once at 19 degrees Celsius, once at 18 degrees Celsius and once at 16 degrees Celsius.

When interviewed, two Registered Nurses stated if the air temperatures were monitored below 22 degrees they have been directed to contact the maintenance department. One RN provided documentation to support they had contacted the maintenance department when the air temperature was 18 degrees Celsius on a specified date in May 2025.

When interviewed the Maintenance Manager confirmed registered staff have been trained to contact the maintenance department if the air temperature is below 22 degrees Celsius and was able to provide documentation to support they had been notified on a specified date in April 2025 due to the residents stating they felt cold. The maintenance manager could not provide documentation to support the maintenance department had been notified the remaining 65 times the air temperatures were monitored and documented below 22 degrees Celsius.

Sources: Air Temperature Logs, Interviews with RN's and the Maintenance Manager.

This order must be complied with by July 11, 2025

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1) A) Educate PSW #104, #107 and #109, on resident and staff hand hygiene requirements during meal service, including requirements of staff to support residents with performing hand hygiene prior to meals, as per evidence based best practice standards.

B) Perform two audits each week, alternating meals (e.g. breakfast, lunch and supper), on hand hygiene during meal service for a period of 4 weeks in the small dining room from the date of the Licensee report being issued.

C) Take corrective actions to address non-compliance related to hand hygiene as identified in the audits.

D) Written records, which will include the date the education was provided and by whom, of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

2) A) Educate HCA #116 and PSW #117 on additional precautions and donning appropriate PPE as per evidence based best practice standards.

B) Perform weekly audits when HCA #116 and PSW #117 are on shift for a total of 4 weeks until appropriate donning of PPE is achieved.

C) Take corrective actions to address non-compliance related to PPE as identified in the audits of part B.

D) Written records, which will include the date the education was provided and by whom, of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that staff perform hand hygiene, as part of the IPAC program, was followed by staff during meal service in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes revised September 2023" (IPAC Standard).

Specifically, the inspector observed three PSW's consistently not perform hand hygiene in between resident interactions (which included touching either the resident or their wheelchair/walker or feeding them). A PSW also did not perform hand hygiene when entering or leaving the dining room, as required in the Hand Hygiene Program requirement 9.1 b) under the IPAC Standard.

Sources: Inspector observations, and interview with PSWs

The licensee has failed to ensure that staff adhere to additional precautions criteria and wear appropriate personal protective equipment (PPE) when required to so, in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes September 2023" (IPAC Standard).

Specifically, a HCA and a PSW did not follow the posted additional precautions in place for a resident. The resident was on contact precautions, and two staff were not wearing a gown while assisting the resident to get into bed, as required in the Additional Precautions Program requirement 9.1 d) under the IPAC Standard.

Sources: inspector observations, interview with a HCA and IPAC lead.

This order must be complied with by July 11, 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.