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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 26, 2014	2014_295556_0030	O-00853-14	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

WENDY PATTERSON (556), HUMPHREY JACQUES (599), LISA KLUKE (547), 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): Sep 15, 16, 17, 18, 19, 22, 23, 24, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nursing and CQI Coordinator, Support Services Manager, Maintenance Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers (HSKP), Activities Director, Cook, Dietary Aides, Nursing Clerk, Vice-President of the Resident’s Council, Residents, and Family Members.

During the course of the inspection, the inspector(s) toured resident care areas and non-residential areas, reviewed residents’ health care records, reviewed infection control policies, environmental services policies, reviewed menus, medication administration policies, complaints handling policy, restraint policy and procedures, resident council minutes, documentation of family information meetings, Oral Care Protocol Policy and mouth care program, Valley Manor Back Care Program, and the home’s abuse training program, observed residents meal and nourishment services, and observed medication administration.

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care.

During the dining observation completed in Stage 1 of the Resident Quality Inspection (RQI), LTCH Inspector #138 observed many residents in the dining room sitting on a transfer sling while seated in their wheelchairs. On September 22, 2014, during the first seating of the lunch dining service, LTCH Inspector #138 identified ten residents who were seated on a transfer sling in their wheelchair. The inspector reviewed the plan of care, as identified by the home, for the ten identified residents and noted that only two of the ten residents were care planned to sit on a transfer sling while in a wheelchair. Seven of the residents, Resident #001, #004, #007, #015, #022, #023, #024, and #035, had no direction in the plan of care relating to the use of a sling while seated in a wheelchair. Resident #004 had direction in the plan of care to not allow the resident to sit on a transfer sling when skin break down was present. The progress notes on the health care record for Resident #004 were reviewed by the inspector and a progress note dated September 16, 2014 identified the resident as currently having skin breakdown. Another progress note dated September 22, 2014 from the rehab assistant recommended removing the transfer sling while the resident was seated in the wheelchair.

On September 23, 2014, LTCH Inspector #138 spoke with a health care aid, Staff #S120, who stated that it is the general practice in the home to leave the transfer slings under residents while a resident is sitting in a wheelchair.

On September 23, 2014, LTCH Inspector #138 spoke with the Director of Nursing (DON) regarding the use of transfer slings. The DON stated that it is common practice in the home for staff to leave a transfer sling under a resident sitting in a wheelchair and directed the inspector to speak with a registered nurse in charge of the transfer sling program.

On September 23, 2014, LTCH Inspector #547 spoke with the registered nurse, Staff #126, who leads the home's transfer sling program. Staff #126 stated that residents are only to be seated on a transfer sling in a wheelchair if the plan of care directs staff to do so. Staff #126 further stated that staff are routinely leaving the transfer slings under residents seated in the wheelchairs as a general practice and that the home is required to take further action to change this practice. [s. 6. (7)]

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 transfer slings are not left under residents unless indicated in the resident's plan of care, to be implemented voluntarily.

WN #2: 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 :

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

Observations of resident rooms were completed as a required task of Stage 1 of the Resident Quality Inspection (RQI). During the observations of resident rooms, Long Term Care Homes (LTCH) Inspectors #138 and #547 observed that the privacy curtains in shared resident rooms (where there were two residents to a room) were not always long enough to be able to afford total privacy to a resident. Specifically, LTCH Inspector #547 identified that the privacy curtain in shared rooms 117-1 and 112-1 left an approximate 12 inch opening when extended fully, preventing full privacy to the resident. LTCH Inspector #138 observed that the privacy curtains in the shared rooms of 3-1, 9-1, and 12-1 left a 4 to 10 inch opening on either side of the privacy curtain when the curtain was fully extended, again preventing full privacy to residents in those rooms.

On September 19, 2014 LTCH Inspector #138 toured four additional shared resident rooms and noted that the privacy curtains in the first bed of these rooms did not afford the resident total privacy.
Specifically:
Room 4-1: there was an opening of 4 inches on the right side of the privacy curtain and an opening of 10 inches on the left side when the curtain was fully extended.
Room 5-1: there was an opening of 15 inches on the right side of the privacy curtain and an opening of 11 inches on the left side when the privacy curtain was fully

extended.
Room 7-1: there was an opening of 15 inches on the right side of the privacy curtain and an opening of 11 inches on the left side when the privacy curtain was fully extended.
Room 8-1: there was an opening of 9 inches on the right side of the privacy curtain when the privacy curtain was fully extended.

LTCH Inspector #138 spoke with the resident in one of the rooms specified above regarding the privacy curtain and Resident #025 stated that he/she is not afforded adequate privacy with the privacy curtain in his/her room. He/she further stated that because of the lack of privacy he/she will get up early in the morning to do his/her own care before there are too many people in the hallways at the home.

On September 22, 2014, LTCH Inspector #138 spoke with the Manager of Support Service regarding the privacy curtains in the shared resident rooms. The Manager of Support Services toured several shared resident rooms with the inspector and agreed that the privacy curtains did not always afford residents with adequate privacy. [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 residing in a bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents have a resident-staff communication response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On September 17, 2014 at 9:38am Inspector #556 observed that Resident #035's communication response system (call bell) was attached to the bed rail at the head of the bed and dangling down toward the floor. The resident was sitting in a wheel chair about three feet away from the head of the bed. The resident stated that he/she had to go to the bathroom but had not been able to reach the call bell to alert the staff because the call bell was too far away.

On September 18, 2014 Inspector #547 noted in bed 1 of a specified room the resident's call bell was located under the blankets and clipped to the mattress, and was not easily seen or accessible to be used by anyone in this resident area. [s. 17. (1) (a)]

2. On September 17, 2014 Inspector #556 noted Resident #034 was sitting in the resident's bed room beside the bed in a broda chair, the resident-staff communication response system (call bell) was under the covers. The resident was not close enough to access the call bell.

On September 18, 2014 Inspector #547 noted Resident #034 to be sitting in a broda chair in his/her room, and the resident call bell was located at the top of the bed under the blankets of the bed and was not easily seen, or accessible by anyone in this resident room. [s. 17. (1) (a)]

3. On September 15th and 17th, 2014, Inspector #138 noted that resident #013 was in a wheelchair in his/her room and the call bell was not provided to him/her. The Resident would not have been able to get the call bell due to his/her mobility and location of the resident's chair.

On September 18, 2014 Inspector #547 noted that Resident #013 was seated in a wheelchair in the middle of the room with the call bell attached to his/her shirt however the resident in bed 1, did not have a call bell as it was lying on the floor, not within the resident's reach, and he/she wanted to call for the nurses.

Inspector #547 interviewed Staff #S100 who indicated that the resident's bell must have fallen to the floor, and should be clipped to the resident's bed and within reach for the resident at all times. [s. 17. (1) (a)]

4. On September 16, 2014 after lunch at 12:30, Inspector #138 observed that Resident #004 was in his/her room sitting in a wheelchair next to the bed. The resident's call bell was not within reach and it was clipped to the bed rail. Resident #004 would not have been able to retrieve the call bell.

On September 18, 2014 at 9:50am Inspector #547 observed Resident #004 sitting in a wheelchair in his/her room with his/her affected right side facing the bed and the call bell was hanging from the bed rail near the top of the bed and not within reach of the resident.

Inspector #547 along with Staff #S100 observed Resident #004 at 11:20am to be lying in bed and the resident did not have access to the call bell. Staff #S100 indicated the resident should have had the call bell, and that the expectation is to make sure that residents have their call bells at all times, or can reach them. Staff #S100 placed the call bell near the resident.

On September 18, 2014 Inspector #547 interviewed the Director of Nursing (DON) regarding the residents' call bells that were observed to not be visible, and/or accessible. The Director of Nursing indicated that the home's expectation is that all

residents have access at all times to their call bell, and the call bell should be positioned in view for anyone entering the resident rooms. [s. 17. (1) (a)]

5. On September 18, 2014 Inspector #547 noted that Resident #037 did not have a call bell while lying in bed. The call bell was on the floor and not within reach. The Resident indicated that he/she wanted to call for the nurses as his/her stomach was upset.

Upon review of the resident's care plan it was noted that this resident is a high risk of falls, and that staff are to re-enforce the need for the resident to call for assistance and to ensure the call bell is pinned to the resident's gown when in bed.

Inspector #547 interviewed Staff #S100 who indicated that the resident's call bell must have fallen to the floor, and should be clipped to the resident's bed and within reach of the resident at all times. [s. 17. (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 ongoing monitoring of the placement of resident-staff communication and response system (call bells) so that they are easily seen, accessed, and used by resident, staff, and visitors at all times, 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 :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On September 19, 2014 Inspector #547 observed staff #S107 and staff #S108 in a

specified room with a resident who was on contact precautions as per the sign on the door of this private room. The sign indicated that staff were to use a mask, gloves and a gown when in direct contact with the resident where the skin or clothing will get wet. The staff did not have personal protective equipment (PPE) gowns while repositioning the resident after lunch. It was further noted that staff #S107 was not wearing any PPE other than gloves while carrying the resident's soiled linens from the resident's bed to the red linen bag in the resident's bathroom. Inspector #547 interviewed #S107 and #S108 as they were leaving the isolated room, and both confirmed that they repositioned the resident after lunch and changed the linen and were not wearing the proper PPE as indicated on the sign on the resident's door.

On this same date, Inspector #547 interviewed staff #S110 and staff #S123 who indicated that the resident in bed 1 of another specified room was also on isolation for respiratory precautions. It was observed that the sign on the door for this resident indicated contact precautions, and that a mask, gloves and gown were required when in direct contact with the resident where the skin or clothing will get wet. Staff #S123 was currently feeding this isolated resident wearing only a mask and gloves. Staff #S110 who was also standing near this resident indicated that staff do not need to wear a PPE gown when they are feeding isolated residents. Staff #S110 was not wearing any mask, gloves or gown at this time. Inspector #547 interviewed staff #S134 who was replacing the home's infection control lead, who indicated the home's expectation is that with respiratory outbreak, the required PPE are gloves, mask and gown at all times when working within 2 meters of the isolated resident.

On September 23, 2014 in a shared bathroom for a specified room Inspector #547 observed a green rolled up wet facecloth with brown matter sitting on top of a white towel that also had brown matter embedded sitting beside the sink on the bathroom counter. Inspector #547 interviewed staff #S129 who indicated that between caring for residents in this shared room he/she would place soiled linen on the counter until the next resident was cared for, and then bring both sets of soiled linen to the soiled utility room. Staff #S129 further indicated there was no need to have the counter and sink disinfected once the linen was removed. In an interview housekeeping staff #S105 indicated that nursing staff did not ask him/her to clean any counter in any resident bathroom on this same day.

On September 24, 2014 Inspector #547 interviewed staff #S118 who indicated that soiled linen are never to be placed on the resident's bathroom counter or furniture as they are to be placed in the soiled utility room after care is completed. Staff #S118

further indicated each resident is cared for separately as staff have to wash their hands between each resident. [s. 229. (4)]

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 nursing staff are re-educated regarding infection control practices and the use of Personal Protective Equipment, and monitoring is implemented to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #020 was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On September 22, 2014 at 12:33pm in the lounge outside the nurses station Inspector #556 observed RPN #S115 perform a diagnostic test on resident #020. There were 6 other residents in the lounge at the time the test was performed.

In an interview at the time of the occurrence #S115 stated the test that she conducted on Resident #020 was a specific diagnostic test.

In an interview the Nursing and CQI Manager stated that it is not acceptable for registered staff to perform diagnostic testing in the lounge in front of other residents. She further stated that for the dignity of the resident receiving the test, and the dignity and respect of the other residents in the room, Resident #020 should have been taken to a private area before the test was conducted. [s. 3. (1) 1.]

2. The Licensee has failed to ensure that the personal health information of residents is kept confidential.

On September 23, 2014 Inspector #599 observed the administration of medications. Registered Staff #S114, #S115 and #S116 discarded the empty medication pouches containing personal health information for residents #021, #047, #046 into a brown paper bag which was secured by tape to the garbage container on the side of the medication cart. Registered Staff #S114, #S115 and #S116 stated this is the normal practice for disposal of the empty medication pouches, and the brown paper bag is then disposed of in the general garbage for the home.

In an interview the Support Services Manager stated that the home's general garbage is kept in a holding area and the contractor picks it up three times a week to be disposed of at the town land fill site. [s. 3. (1) 11. iv.]

WN #6: 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. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident’s plan of care. 2007, c. 8, s. 31. (1).

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).

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:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of Resident #020 by a physical device was included in the resident’s plan of care.

On September 16th, 22nd and 23rd, 2014 Resident #020 was observed in a broda chair with a table top in place. When Inspector #556 asked the resident if he/she could remove the table top the resident did not respond.

In an interview PSW #S124 stated that resident #020 is not able to take off the table top, and RPN #S115 stated that resident #020 may be able to move the table top away from his/her body but would not be able to push it right off since the table top is tightly secured to the chair.

In an interview the Nursing and CQI Coordinator stated she doesn't know why resident #020 has a table top in place since the resident doesn't use it for anything and if it serves no purpose then it is considered to be a restraint. She further stated that all restraints should be included in the resident’s care plan.

A review of Resident #020’s health care record was conducted and the use of a table top was not found to be included in the resident’s plan of care. [s. 31. (1)]

2. The licensee failed to ensure that a physician, or registered nurse in the extended class ordered or approved the restraining of Resident #020.

On September 16th, 22nd and 23rd, 2014 Resident #020 was observed in a broda chair with a table top in place.

In an interview both PSW and Registered staff indicated that the resident was not able to remove the table top.

In an interview the Nursing and CQI Coordinator stated that the home requires that all restraints have a physician's order on file.

A review of Resident #020’s health care record indicated that there was no physician or registered nurse extended class order for the table top restraint being used for Resident #020. [s. 31. (2) 4.]

3. The licensee has failed to obtain consent from Resident #020 or the Substitute Decision Maker for restraining by a physical device.

On September 16th, 22nd and 23rd, 2014 Resident #020 was observed in a broda chair with a table top in place.

In an interview both PSW and Registered staff indicated that the resident was not able to remove the table top.

A review of Resident #020’s health care record was conducted and no written consent for the restraining of the resident was located.

In an interview the Nursing and CQI Coordinator stated that the home requires that all restraints have consents on file. [s. 31. (2) 5.]

WN #7: 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 and snack.

Long Term Care Homes Inspector (LTCH) Inspector #138 observed the lunch meal service upon entry to the home as this is a required task of Stage 1 of the Resident Quality Inspection (RQI). During the dining observation, the inspector observed that substitutions were made to the lunch meal as indicated on the home's weekly menu. The inspector continued to monitor several meal services throughout the course of the RQI from September 15 – 24, 2014 and noted that frequent substitutions were made to the menu each day making the menu unpredictable.

LTCH Inspector #138 spoke with the Vice-President of the Residents' Council on September 19, 2014 regarding the frequency of menu substitutions observed by the inspector. The Vice-President of the Residents Council stated to the inspector that the menu substitutions are frequent and that this is common in the home. The Vice-President of the Residents Council further stated that this has come up in the council meetings from other residents but that it was not considered an issue as the menu substitutions were considered by the residents to be appropriate. The Vice-President of the Residents Council further stated that it can be disappointing to look at the weekly menu in advance only to have it change prior to the meal service.

LTCH Inspector #138 obtained the production sheets that corresponded with the menu from September 15, 2014 to September 24, 2014 and confirmed multiple daily substitutions to the menu. The inspector also reviewed documentation that outlined the reasons for the menu substitutions. The most common reason documented for menu substitution was to allow for the use of previously used menu items known as leftovers.

LTCH Inspector #138 spoke with the Support Service Manger regarding the frequency of the menu substitutions and she stated that menu substitutions do occur but the home is working to limit such substitutions by implementing a policy to avoid the use of leftovers. This policy is expected to be implemented with the introduction of the upcoming fall/winter menu. [s. 71. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The license has failed to ensure that a PASD used under section 33 of the Act is applied by staff in accordance with any manufacturer's instructions.

During Stage 1 of the Resident Quality Inspection (RQI), Long Term Care Homes (LTCH) Inspector #138 observed that Resident #004 was seated in a wheelchair with a lap belt applied over the resident's pelvis. The inspector observed that the lap belt was loose and that it could be pulled away from the resident's body approximately 4 to 6 inches.

The inspector observed the resident throughout the course of Stage 1 of the RQI and observed that the lap belt was consistently applied loosely.

LTCH Inspector #138 reviewed Resident #004's current plan of care defined by the home and noted that the resident was planned to wear a PASD (lap belt) while up in a wheelchair at the resident's request. The inspector also noted that there was a corresponding physician's order for the PASD (lapbelt).

On Sept 23, 2014, LTCH Inspector #138 spoke with the Director of Nursing (DON) regarding the application of lap belts. The DON directed the inspector to the Valley Manor Back Care Program 2013 booklet which contained an insert regarding the positioning and fit of lap belts. The DON stated that this insert directs staff to fit the lap belt snug to the body so that there is only sufficient room to slide one's hand between the lap belt and the body. She further stated that a lap belt should not be loose enough to be pulled several inches away from the body.

On September 23, 2014 LTCH Inspector #138 spoke with a health care aide, Staff #S122, regarding the application of Resident #004's lap belt. Both the inspector and the health care aide proceeded to the resident and observed the lap belt to be loose. Staff #S122 stated that the lap belt was too loose and proceeded to correctly adjust the lap belt. [s. 111. (2) (a),s. 111. (2) (b),s. 111. (2) (c)]

WN #9: 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 are stored on a medication cart, that is secure and locked.

On September 19, 2014, Inspector #547 observed a medication cart in the zone two resident hallway that was not locked and not attended by any registered staff.

Resident #039 resides in zone 2, is diagnosed with a specific disease, regularly ambulates up and down the zone 2 hallway, and was standing beside the medication cart that was not attended by any registered staff.

Inspector #547 remained with the resident until RPN #S111 returned to the unattended medication cart after going to zone 3 resident hallway to get a thermometer. Zone 3 hallway is around the corner from zone 2 and out of sight of the medication cart. RPN #S111 indicated that she must not have closed the medication cart properly when she left, but that it should always be kept locked when it is not attended. [s. 129. (1) (a) (ii)]

Issued on this 26th day of September, 2014

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