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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Nov 1, 2013	2013_128138_0043	O-000306-13 O-000898-13	Critical Incident System

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

PAULA MACDONALD (138)

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): October 29 and 30, 2013

Additional inspector was in attendance during the course of the inspection for training purposes only.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator, and a Personal Care Worker (PSW).

During the course of the inspection, the inspector(s) reviewed two Critical Incident Reports, reviewed the home's Zero Tolerance of Abuse and Neglect Policy, Valley Manor Falls Prevention and Management Policy and Procedure (reviewed date of May' 12), and Head Injury Routine (Nursing Policies and Procedures dated Nov'10 and a second revised policy dated April 23rd, 2013), reviewed a resident health care record, reviewed internal incident documents, reviewed a portion of an employee file, and reviewed the home's education program and tracking.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

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 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 :

1. The licensee failed to comply with O. Reg 79/10 s. 8. (1) (b) in that the licensee did not comply with policies required under the legislation.

During the course of the inspection, Long Term Care Home Inspector #138 reviewed a Critical Incident Report that outlined that Resident#1 had a fall with a head injury resulting in palliative care for the resident. In accordance with O. Reg 79/10 section 8, 30, 48 and 49, the licensee is required to have in place a fall prevention and management program with supporting policies. While in the home, the inspector reviewed the home's policy titled Valley Manor Falls Prevention and Management Policy and Procedure which was provided to the inspector by the Clinical Coordinator. It was noted by the inspector that this policy indicated that after a fall has occurred the Substitute Decision Maker (SDM) or family if SDM is not available is to be notified.
Long Term Care Home Inspector spoke with the Clinical Coordinator regarding Resident #1's fall on a specified date in April 2013. During this discussion, the Clinical Coordinator stated that the family was upset that they had not been informed of the resident's fall immediately after it had occurred and that the family had met with the home's Administrator to discuss this concern several days after the fall.
Long Term Care Homes Inspector then spoke with the Director of Care about the home's practice of informing a resident's SDM once the resident has had a fall. The Director of Care stated that the nursing staff will notify the SDM but will make a judgement as to when this would be appropriate. In the case of Resident #1's fall in April 2013, the Director of Care stated that the nurse made the judgement to contact the resident's SDM the following morning.
Long Term Care Homes Inspector then spoke with the Administrator regarding her meeting with Resident #1's family days after his/her fall in April 2013. The Administrator stated she did meet with the family which included the resident's SDM. The purpose of the meeting was to discuss several items one being the family's concern that they were not notified immediately when the resident fell.
Resident #1's health care record was reviewed and the progress note outlining the resident's fall did not indicate that the SDM was notified. The progress notes were further reviewed and an additional progress note time stamped ten hours later indicated that the resident's SDM was notified of the resident's fall.
The home did not follow it's fall prevention and management policy and did not contact Resident #1's family or SDM following his/her fall in April 2013.

During the inspection, Long Term Care Home Inspector reviewed a resident health care record related to a fall with a head injury. It was noted by the inspector that a

head injury routine had been initiated after Resident #1's fall on a specified date in April 2013. The home's Head Injury Routine policy in place at the time of the fall, provided by the Director of Care, outlined that vital signs and pupil reactions were to be taken every 15 minutes for the first hour, then every half hour for the next two hours, and then every 2 hours for a 24 hour period. The head injury routine documentation for Resident#1's fall was further reviewed by the inspector and it was noted that the resident was not assessed as frequently as outlined in the home's Head Injury Routine policy. The inspector further reviewed Resident #1's chart and noted from the progress notes that s/he had fallen twice previously both times sustaining a head injury. The head injury routine documentation for both of these falls was reviewed and it was noted by the inspector that the resident was not assessed as frequently as outlined in the home's Head Injury Routine policy.
The inspector spoke with the Director of Care who provided an additional incident whereby nursing staff did not initiate a head injury routine when expected by the home. The Director of Care stated that she acknowledged that the implementation of the home's Head Injury Routine policy requires improvement.

During the inspection, Long term Care Homes Inspector reviewed another Critical Incident Report that reported suspected physical abuse to a resident. In accordance with LTCHA 2007 section 20 and O.Reg 79/10 section 8, 96 and 104, the licensee is required to have a policy in place to promote zero tolerance of abuse and neglect and that the licensee is required to report all investigations of abuse and neglect to the Director. While in the home, the inspector reviewed the home's policy titled Zero Tolerance of Abuse and Neglect. This policy states that the final investigation report will be submitted to the Director through the Ministry Critical incident System within 21 days which is consistent with legislative requirements. The Critical Incident Report was further reviewed by the inspector and it was noted that the home became aware of the suspected abuse on a specified date in August 2013 but that the final investigation report was not submitted to the Director until a specified date in September 2013, which was seven days after the required reporting time frame. Discussion was held with the Administrator and she indicated that the home's investigation into the incident had been completed within the 21 days but that the report was submitted seven days after the required time frame. [s. 8. (1)]

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 home's Head Injury Routine policy is complied with, to be implemented voluntarily.

Issued on this 1st day of November, 2013

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