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
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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
Apr 13, 2015	2015_295556_0010	O-001513-15, O-001463-14	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

WENDY PATTERSON (556)

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 9 & 10, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Maintenance Manager, Registered Nurse (RN), Personal Support Workers (PSW), and Health Care Aide (HCA).
The Inspector reviewed Resident Health Care Records, several policies, observed a mechanical lift transfer, reviewed Lifts & Transfers Staff Education materials and records, reviewed Internal Correspondence and Internal Investigation Documentation, reviewed Equipment Service Provider Service Call Reports and the Equipment Service Provider Service Agreement, and reviewed the Manufacturers Instructions for Maxi Sky 600 Ceiling Lifts.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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 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 has failed to ensure that the care set out in the plan of care was provided to Resident #001 as specified in the plan.

During the course of an inspection into an incident that occurred on a specific date the Critical Incident Report was reviewed. The Report, submitted to the MOHLTC by the home, indicated that Resident #001 fell out of bed while being provided morning care in the bed by one PSW. The resident sustained a fracture as a result of the fall. The report further stated that two 1/4 length side rails were on the bed in the raised position at the time of the incident.

The Care Plan that was in effect for Resident #001 at the time of the incident was provided to Inspector #556 by the Resident Care Coordinator. The Care Plan indicated that two 3/4 length side rails were to be up at all times when in bed for safety.

A review of the home's internal investigation documentation stated that prior to the incident 3/4 length bed rails had been used on Resident #001's bed.

In an interview HCA #100 stated that she was providing morning care to Resident #001 on the day the incident occurred when the resident spiraled out of the bed and onto the floor. HCA #100 further stated that she didn't notice that the rails on Resident #001's bed were different.

In an interview the Administrator stated that as per the plan of care Resident #001 was to be in a bed with two 3/4 length bed rails for safety, however the beds were removed from the room 3 days prior to the incident while the floors were waxed and when the beds were put back into the room Resident #001 was accidentally given a bed with two 1/4 length bed rails. [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 a process is developed and implemented to ensure that the beds of residents who require bed rails are inspected daily to ensure the correct bed rails are in place, to be implemented voluntarily.

Issued on this 13th day of April, 2015

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

Original report signed by the inspector.