Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 1, 2, 7, 10, 13, 2012	2012_054133_0030	Critical Incident

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Activities Director, Registered and non registered nursing staff and a restorative care worker.

During the course of the inspection, the inspector(s) reviewed a Critical Incident report, reviewed documentation related to this reported incident, reviewed resident #001's health care record, reviewed the home's Behavioral Support Team (BST) meeting minutes July 18/12 and reviewed behavioral interventions documented by the BST spanning an identified time frame for resident #001.

The on-site inspection was conducted on August 1st and 2nd, 2012

The following Inspection Protocols were used during this inspection:

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, , 2007, s.6(10)c in that a resident was not reassessed and the plan of care was not reviewed and revised when care set out in the plan has not been effective.

It was reported to the Ministry of Health and Long Term Care (MOHLTC) by the home via a Critical Incident report that on a day in June 2012, resident #001 was found outside of the home by a staff member. As reported by the home, resident #001 has a history of exit seeking and wandering. The resident has been identified by the home to be at high risk of elopement. This is the resident's second elopement reported to the MOHLTC within the last year.

During the on site inspection of August 1st, 2nd, 2012, the inspector reviewed the resident's care plan as well as other documentation related to resident #001's wandering and exit seeking behavior, as provided to the inspector by the Director of Care. It is noted by the inspector and acknowledged by the Director of Care that resident #001 was not reassessed and his/her plan of care was not reviewed and revised subsequent to his/her elopement on a day in June 2012, which signaled that the care set out in the plan related to his/her exit seeking behavior had not been effective.

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 with the requirement that a resident is reassessed and and the plan of care reviewed and revised when care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 13th day of August, 2012

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