Ontario

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
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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
Jun 13, 15, Jul 21, 2011	2011_048175_0006	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

BRENDA THOMPSON (175)

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 Administrator Linda Shulist, Director of Care G. Yantha, Registered Nurses,Personal Support Workers and Constable Kyle Fabian.

During the course of the inspection, the inspector(s) reviewed the Home's Critical Incident Report #2675-000016-10, Article 42-Abuse Policy, 2 Staff Memos from Administrator L. Shulist to All Staff, dated January 20, 2011 and April 6,2011 respectively, and resident's health records.

The following Inspection Protocols were used in part or in whole during this inspection:

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Definitions	Définitions
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 sayants :

1. Critical Incident Report # 2675-000016-10 submitted Dec. 30, 2010, was reviewed and indicated an RPN witnessed a man in a resident's bedroom, sitting next to her and lifting her shirt, touching her left breast. The man was identified as a visitor to the home. 4.The resident's plan of care was not reviewed or revised subsequent to her involvement in the incident of witnessed abuse Dec. 30, 2010. 3.The licensee did not ensure that the resident is reassessed and the plan of care reviewed and revised to include interventions for monitoring and supervision related to the reported incident of abuse by a visitor, in the resident's room.
2. According to an interview with the Administrator of the Home Linda Shulist, it was necessary to discontinue weekly visits of the family member of a resident from Dec. 30, 2010, to Jan. 20, 2011, pending investigation of witnessed incident of inappropriate touching of another resident. 2. January 20, 2011, the resident's weekly visits were restricted, requiring staff intervention. 3.A staff memo dated Jan. 20, 2011, indicated all specific directions related to visitation restrictions. 4.An interview with the Director of Care indicated she did not see where the care plan was revised related to the family member's complete and/or partial visitation restrictions.
5. The licensee did not ensure that the resident's plan of care was revised when the resident's care needs changed related to discontinuation and restrictions to the family member's weekly visitation.

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 s. 6(10)(b)to 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, the resident's care needs change., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits sayants :

1. Gail Yantha, Director of Care was interviewed and reported " No long term corrective actions have been put in place to prevent a recurrence that I am aware of. "
2. Critical Incident Report #2675-000016-10 dated Dec. 30, 2010, submitted to the Ministry of Health and Long Term Care, requesting information from the Home regarding Analysis and Follow-up action relating to the reported incident, indicated "No further actions at this time. Will continue to observe resident for any adverse effects". The licensee failed to include the long-term actions planned to correct the situation and prevent recurrence.

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 s. 104 (1) in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence. , to be implemented voluntarily.

Issued on this 28th day of July, 2011

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