Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 1, 2020 | 2020_779641_0023 | 010148-20, 010732-20 | Complaint |

### 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

CATHI KERR (641)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): August 7, 11, 12, 13, 2020.**

**This inspection was conducted in reference to intake log #010732-20 and intake log #010148-20, CIS #2675-000008-20, related to a complaint of alleged staff to resident abuse of resident #001.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of Care. the Nursing Care Coordinator, Registered Nurses, Personal Support Workers, family members and the resident.**
**During the course of the inspection, the Inspector observed staff to resident interactions, reviewed resident health care records and Critical Incident System reports (CIS) and relevant licensee investigation notes; observed video surveillance tapes and reviewed policies and procedures related to zero tolerance of abuse and neglect and skin and wound care.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the SDM had been given an opportunity to participate fully in the development and implementation of the plan of care for resident #001 after receiving an injury on a specified date.

Critical incident #2675-000008-20 and a complaint received from the resident's family, indicated that the resident had received an injury on a specified date. The complainant indicated that the Substitute Decision Maker (SDM) had not been notified of this injury, and only became aware of it when the resident mentioned the injury to a family member and it was observed on a video call with the resident five days later.

During an interview with Inspector #641 on August 11, 2020, the Nursing Care Coordinator indicated that when resident #001 received the injury, the SDM should have been notified of the injury that day and they hadn't been.

Inspector #641 interviewed RN #106 on August 12, 2020. The RN indicated they had observed and treated the injury to resident #001 on the specified date and they had not notified the SDM or any of the family, after having treated the injury. RN #106 advised that when there was a change in the resident's condition, they would normally contact the family to notify them of what had occurred.

The licensee failed to ensure that the SDM had an opportunity to participate in resident #001's plan of care after receiving the injury on the specified date. [s. 6. (5)]

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**Issued on this 1st day of September, 2020**

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

**Original report signed by the inspector.**