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
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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
Nov 28, 2014	2014_159178_0024	T-103-14	Resident Quality Inspection

Licensee/Titulaire de permis

ADVENT HEALTH CARE CORPORATION
541 Finch Avenue West NORTH YORK ON M2R 3Y3

Long-Term Care Home/Foyer de soins de longue durée

VALLEYVIEW RESIDENCE
541 Finch Avenue West NORTH YORK ON M2R 3Y3

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

SUSAN LUI (178), ANN HENDERSON (559), DIANE BROWN (110), JULIENNE NGONLOGA (502), TILDA HUI (512)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 2, 3, 6, 7, 8, 9, 10, 14, 15, 16, 2014.

The following Critical Incident Intakes were inspected during this RQI and the results are included in this report:
T-228-14, T-758-14, T-963-14, T-977-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Family and Resident Relations Coordinator, Food Service Manager, Environmental Service Manager, nurse managers, Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator/Restorative Care Manager, Programs Manager, Office Manager, registered staff, personal support workers (PSWs).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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During the course of this inspection, Non-Compliances were issued.
11 WN(s)
9 VPC(s)
1 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review indicated that on May 2, 2014, resident # 001 was assessed to have a stage three pressure ulcer. Between May 2, 2014 and August 13, 2014, the resident was not reassessed at least weekly by a member of the registered nursing staff.
Record review confirmed that skin assessments were not conducted for the resident between May 2, 2014 and May 15, 2014, between May 23, 2014 and June 13, 2014, and between June 17, 2014 and August 13, 2014.

Record review confirmed that during the period between May 2, 2014 and August 13, 2014, resident # 001's pressure ulcer did not heal, and increased in size by 0.5 cm.

Interview with the home's lead for the skin and wound care program confirmed that resident # 001's pressure ulcer was not reassessed weekly between May 2 and August 13, 2014, and that weekly skin assessments should be conducted for all residents with altered skin integrity, including those who exhibit pressure ulcers. [s. 50. (2) (b) (iv)]

2. Record review indicated that on January 17, 2014, resident #012 was assessed to have a stage three pressure ulcer. Record review confirmed that between January 17, 2014 and April 13, 2014, the resident's skin was not reassessed at least weekly by a member of the registered nursing staff.

Interview with the home's lead for the skin and wound program confirmed that resident #012 was not reassessed at least weekly by a member of the registered nursing staff, and that weekly skin assessments should be conducted for all residents with altered skin integrity, including those who exhibit pressure ulcers.

Non-compliance with O. Reg. 79/10, s. 50. (2)(b)(iv) was previously identified in Resident Quality Inspection # 2013_159178_0006, dated April 9, 2013, and a Voluntary Plan of Correction (VPC) was issued at that time. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the right of a resident to be treated with courtesy and respect was fully respected and promoted.

On October 2, 2014, during lunch meal services, the inspector heard and observed an identified PSW speak to resident #057 in a disrespectful manner. The following conversation was heard by the inspector:
Resident #057 told the identified PSW that he/she does not have respect toward the residents. The identified PSW replied to the resident "Respect given, where respect due", and added "MYOB". The identified PSW put his/her hand on resident #057's shoulder and said to the resident, "you are always complaining, you are never satisfied, now the Ministry is here and you are still complaining". Resident #057 replied to the PSW that "you don't respect me and you should MYOB".
In an interview, resident #057 revealed that he/she is impatient with the way staff speak to the residents. The resident stated it is very disrespectful, and confirmed that the identified PSW had told him/her to "MYOB", meaning mind your own business, and indicated that it made him/her feel disrespected.

Staff interview indicated that another resident spoke to the PSW in a childish manner and the PSW was replying to that resident in the same way. Resident #057 intervened to tell the PSW to be respectful toward the resident and the PSW confirmed that he/she said "respect gained, where respect due" to resident #057. When asked what MYOB means, the PSW stated that the inspector should ask the resident. [s. 3. (1) 1.]

2. The licensee has failed to ensure that a resident's right to be properly groomed in a manner consistent with his or her needs was respected.

On October 7, 2014, resident #015 was observed to be unshaven. During interviews, two staff members confirmed that resident #015 is to be shaved on shower evenings, the most recent of which was October 6, 2014. Interview with the resident confirmed he/she had not been shaved on October 6, 2014, or on October 7, 2014. The registered staff confirmed that the resident had not been groomed in a manner consistent with his/her needs. [s. 3. (1) 4.]

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 rights of residents to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity are fully respected and promoted.
-the resident's right to be properly groomed in a manner consistent with his or her needs is respected, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.
Inspectors identified on October 3 and 8, 2014, a missing ceiling tile in the 2W shower room, a heavily soiled window curtain in the 4W hallway, and a heavily soiled couch cushion in the 3W lounge. Staff interviews confirmed that these items should be reported to maintenance for repair and deep cleaning, either by documenting it in the unit maintenance log, or by calling the department.
An interview with the ESM manager confirmed that these items were the responsibility of the maintenance department, and the department had not been notified of these concerns. [s. 15. (2) (c)]

2. On October 2, 2014, the inspector observed in an identified resident washroom, a raised toilet seat assistive device positioned on top of the toilet, but not secured in any way. A long bolt with a cap was noted to be sitting on the washroom counter top.
Staff interviews confirm that the raised toilet seat was not properly secured on the toilet because the bolt had been removed from the device.
On October 6, 2014, the inspector observed that the raised toilet seat assistive device had been replaced and was attached securely to the resident's toilet. [s. 15. (2) (c)]

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, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system is available at each bed location used by residents.

During the course of this inspection, residents #037 and #038 were observed to reside in the same room with a call bell available only at the bed of resident #038. An identified registered practical nurse (RPN) and an identified PSW confirmed that resident #037 does not have a call bell available at his/her bed. [s. 17. (1)]

2. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

Observation made on October 2, 2014 on 4 East revealed that the call bell on the balcony was not functional. An identified PSW confirmed that the call bell could not be activated, and stated that maintenance staff would be informed.

Interview with the environmental services manager confirmed that the call bell was not working. The inspector returned on October 10, 2014, and noted that the call bell had been repaired and was working. [s. 17. (1) (b)]

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 resident-staff communication and response system is available at each bed location used by residents
-the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident receives oral care to maintain the integrity of the oral tissue, that includes mouth care in the morning and evening.

Staff interviews and record review revealed that resident #015 is to receive oral care in the morning and at bedtime. The PSW on day shift stated that this involves brushing the resident's teeth and assisting him/her to rinse with mouth wash. The PSW on evening shift stated that this involves brushing his/her teeth in the evening before bed.

At mid-morning on October 7, 2014, the resident's dry toothbrush was found in the resident's washroom, and the resident's assigned PSW stated this was the toothbrush that was used during that morning's care. The PSW subsequently retracted the statement and confirmed he/she had not cleaned the resident's teeth or assisted him/her to rinse with mouth wash that morning.
Resident #015 confirmed in an interview that the PSW staff did not clean his/her teeth on the evening shift on October 6, 2014, or on the day shift on October, 7, 2014. [s. 34. (1) (a)]

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 each resident receives oral care to maintain the integrity of the oral tissue, that includes mouth care in the morning and evening, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On October 2, 2014, lunch meal service was observed in the four east dining room. Resident #030 was observed at 12:23pm with a bowl of soup in front of him/her while positioned at the table. Also present was the resident's pureed entree, above the bowl of soup and out of reach of the resident. The resident's plan of care revealed that the resident requires feeding assistance. Policy review and an interview with the food service manager confirmed that residents are to be served course by course unless otherwise indicated in their plans of care. [s. 73. (1) 8.]

2. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On October 2, 2014 at lunch meal service in the four east dining room, resident #029

was observed being fed dessert in an approximate 70 degree angle position, whereby the resident was tilted back with his/her eyes in line with the ceiling.
The PSW stated that the resident's chair would not go up further to allow for proper positioning. The registered staff in the dining room was informed of the resident's position by the inspector. The registered staff confirmed that the resident's position was not safe for feeding. The resident was heard clearing his/her throat after the dessert was fed to him/her by staff. An interview with the food service manager and the DOC confirmed that residents should be fed in an upright position with staff maintaining eye contact with the resident. [s. 73. (1) 10.]

3. During breakfast service on October 3, 2014, a PSW was observed standing while assisting resident #039 to drink thickened milk. The PSW repeatedly spooned the fluid into the resident's mouth and wiped the resident's face with the clothing protector. An identified RPN confirmed that this was not the proper technique to assist a resident with eating, that the PSW should be sitting down to assist the resident, and should use the provided napkin to wipe the resident's face. [s. 73. (1) 10.]

4. The licensee has failed to ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking.

On October 2, 2014 at lunch meal service, one PSW was observed providing total assistance with eating to five residents at 3 different tables.
At 12:23p.m. PSW #1 was observed totally assisting resident #031 table 4. The PSW left at 12:30p.m. after a partial meal was served, returning to the resident at 12:42p.m. to finish assisting to feed the resident's entree. PSW #1 moved to assist resident #030 at table four for a partial meal. After a few minutes PSW #1 then left to total assist resident #029 at table five with dessert. At 12:50p.m. PSW #1 sat to totally assist resident #033 with soup. At 12:55p.m. PSW #1 returned to resident #031 to total assist with feeding dessert while also offering a spoonful of pureed entree to neighbouring resident #032 at table four. PSW #1 left table four to finally assist a 5th resident at table #2. An interview with the food service manager revealed that resident table assignments are created to allow one staff member to totally assist two residents with eating. The DOC was unaware that there was a requirement to have one PSW provide total assistance with eating to no more than two residents at one time. The home's nursing policy titled "feeding" does not reference a number of residents requiring feeding to staff ratio. [s. 73. (2) (a)]

5. The licensee has failed to ensure that no resident who requires assistance with eating

or drinking is served a meal until someone is available to provide the assistance required by the resident.

On October 2, 2014 at lunch meal service in the four east dining room, the following observations were made:
Resident #030 was observed at 12:23p.m. with soup and a pureed entree. Assistance was not provided until 12:42p.m. when the inspector inquired to staff regarding the resident's required level of assistance.
Resident #032 was observed with a pureed entree at his/her place setting from 12:23p.m. until 12:41p.m with no staff assistance. At 12:42p.m. one spoonful of entree was offered and refused. From 12:42p.m. until 12:53p.m., no further feeding assistance or attempts were offered. At 12:55p.m. the pureed entree was removed.
Resident #033 was observed at 12:23p.m. with a blended pureed meal in a mug and two beverages. Assistance was not provided until 12:42p.m.
A record review of the plans of care for residents #030, #032 and #033, identified that all three residents require feeding assistance.

During an interview with an identified PSW, the staff member stated that meal service is unorganized and that there is not enough staff available to allow them to stay and assist two residents with their meal at one time. [s. 73. (2) (b)]

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:
-meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs
-proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance
-no person simultaneously assists more than two residents who need total assistance with eating or drinking
-no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

Observation made on October 2, 2014 on 4 West indicated that the door to the janitor closet room #4115 was closed but not locked. A chemical dispenser was observed mounted on the wall inside the janitor closet. The inspector brought the unlocked door to the attention of an identified PSW who contacted the housekeeping department. The door was subsequently locked by a member of the housekeeping staff.

Interview with the Environmental Services Manager confirmed that the door to janitor closet is to be kept locked at all times. [s. 91.]

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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a physical device is used to restrain a resident under section 31 of the Act, all assessment, reassessment and monitoring is documented, including the resident's response.

On October 9, 2014, resident #028 was observed with a seat belt and lap tray restraint in place.
The home's Restraint and PASD (personal assistance services device) policy (NNIIR008vv), dated March 2013, requires registered staff to document a reassessment of the resident's condition and the effectiveness of the restraint every eight hours or whenever necessary. An interview with the nurse manager confirmed that the registered staff is expected to monitor the restrained resident, and sign the restraint flow sheet every shift or 8 hours to indicate that this has been done.
Staff interview and record review confirmed that on day shift on October 9, 2014, the registered staff assigned to resident #028 did not document the assessment or monitoring of the resident while the resident was restrained.
An interview with a registered nurse confirmed that he/she was unaware that resident #028's seat belt and lap tray were restraining the resident. [s. 110. (7) 6.]

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 when a physical device is used to restrain a resident under section 31 of the Act, all assessment, reassessment and monitoring is documented, including the resident's response, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area, or stored in a separate locked area within the locked medication cart.

During an interview with the DOC it was revealed that the registered staff bring discontinued narcotics and controlled substances to the DOC's office where they are stored in a locked drawer until they are destroyed. The DOC stated that the door to the office is considered the second lock to secure the narcotics. On October 2, 2014 at 11:00 a.m., and on October 7, 2014 at 1:55 p.m., the door to the DOC's office was observed to be open and unlocked while the office was unattended.
The DOC confirmed that the door to the office is not always locked. As a result, the narcotics and controlled substances are not consistently stored in a double-locked stationary cupboard. [s. 129. (1) (b)]

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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On October 2, 2014, the following infection prevention and control issues were observed: In two identified shared bathrooms on the fourth floor, several unlabeled personal care items were observed. These items included a wash basin, a bedpan, a white plastic receptacle normally used to hold urine, two drinking glasses. [s. 229. (4)]

2. Observation made on October 2, 2014, noted unlabeled personal care items including three toothbrushes, one hair comb, and one rinse basin in the washroom of room #223 which was shared by two residents.

Observation made on October 3, 2014, noted unlabeled personal care items including a

rinse basin and one tooth brush, in the washroom of room #226 which was shared by two residents. A denture cup was observed to be labeled, however the print ink was faded and the resident's name could not be deciphered.

Interview with a PSW and the DOC confirmed that these personal care items should have been labeled. [s. 229. (4)]

3. It was observed on October 2, 2014 on four west along the hallway outside room #411, that two out of four hand sanitizer dispensers in the hallway were empty. Two of the dispensers were observed to be empty and no hand sanitizer solution was dispensed when the dispensers were activated.

Interview with a registered nursing staff member on duty indicated that hand sanitizer dispensers had been noted to be empty at times by nursing staff who were unable to perform their hand hygiene. The registered nursing staff member stated that he/she was aware that the housekeeping staff were responsible to check and refill the dispensers and wished that the checking could be done more often. Interview with the Environmental Services Manager confirmed that the housekeeping staff is expected to check and refill the hand sanitizer dispensers each shift and the task is part of their daily responsibilities. [s. 229. (4)]

4. During an observation of resident #015's shared bathroom, an unlabeled, old, dirty toothbrush was found in the tooth mug for this resident. This was confirmed by a family member and an identified RPN. [s. 229. (4)]

5. The licensee has failed to ensure that the home provide staff with access to point-of-care hand hygiene agents.

Observation made on October 2, 2014 at 1:40 p.m. noted there was no point of care hand sanitizing agents in shared resident's rooms #223 and #226. There were hand sanitizer dispensers in the hallway.

Interview with registered nursing staff and nurse manager who is the lead for the infection prevention and control program confirmed that there were no hand sanitizer dispensers installed in any of the resident's rooms. [s. 229. (9)]

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:
-all staff participate in the implementation of the infection prevention and control program
-staff is provided with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #11: 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 ensure that the home's policy titled Ordering Medications using the Prescriber's Order Sheet (4-2) was complied with.

The policy requires that when a prescriber's order is processed, two signatures must be evident on the original physician's order sheet. Record review revealed a telephone order for resident #028's restraints was received on October 3, 2014. One nurse's signature was identified on the order. As of October 9, 2014, a second nurse's signature had not been obtained.
An identified nurse manager confirmed the policy was not complied with. [s. 8. (1) (b)]

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

Issued on this 31st day of December, 2014

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

(178)

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178), ANN HENDERSON (559), DIANE BROWN (110), JULIENNE NGONLOGA (502), TILDA HUI (512)
Inspection No. / No de l'inspection :	2014_159178_0024
Log No. / Registre no:	T-103-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 28, 2014
Licensee / Titulaire de permis :	ADVENT HEALTH CARE CORPORATION 541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3
LTC Home / Foyer de SLD :	VALLEYVIEW RESIDENCE 541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MIKE SAVATOVICH

To ADVENT HEALTH CARE CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that resident # 001, resident # 012, and all residents exhibiting pressure ulcers, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
This plan shall be submitted via email to susan.lui@ontario.ca by December 8, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review indicated that on May 2, 2014, resident # 001 was assessed to have a stage three pressure ulcer. Between May 2, 2014 and August 13, 2014, the resident was not reassessed at least weekly by a member of the registered nursing staff.
Record review confirmed that skin assessments were not conducted for the resident between May 2, 2014 and May 15, 2014, between May 23, 2014 and June 13, 2014, and between June 17, 2014 and August 13, 2014.

Record review confirmed that during the period between May 2, 2014 and August 13, 2014, resident # 001's pressure ulcer did not heal, and increased in size by 0.5 cm.

Interview with the home's lead for the skin and wound care program confirmed that resident # 001's pressure ulcer was not reassessed weekly between May 2 and August 13, 2014, and that weekly skin assessments should be conducted for all residents with altered skin integrity, including those who exhibit pressure ulcers. (512)

2. Record review indicated that on January 17, 2014, resident #012 was assessed to have a stage three pressure ulcer. Record review confirmed that between January 17, 2014 and April 13, 2014, the resident's skin was not reassessed at least weekly by a member of the registered nursing staff.

Interview with the home's lead for the skin and wound program confirmed that resident #012 was not reassessed at least weekly by a member of the registered nursing staff, and that weekly skin assessments should be conducted for all residents with altered skin integrity, including those who exhibit pressure ulcers.

Non-compliance with O. Reg. 79/10, s. 50. (2)(b)(iv) was previously identified in Resident Quality Inspection # 2013_159178_0006, dated April 9, 2013, and a Voluntary Plan of Correction (VPC) was issued at that time.

(512)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28th day of November, 2014

Signature of Inspector / Signature de l'inspecteur : (178)

Name of Inspector / Nom de l'inspecteur : SUSAN LUI

Service Area Office / Bureau régional de services : Toronto Service Area Office