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

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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
Jul 10, 2015	2015_340566_0009	T-1761-15	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

ARIEL JONES (566), SUSAN LUI (178), TIINA TRALMAN (162)

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): June 16, 17, 18, 19, 22, 23, 24, 26, 29 and 30, 2015.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T-1255-14, T-1626-15.
The following Critical Incident Intake was inspected concurrently with this RQI: T-990-14.
The following Follow Up Intakes were inspected concurrently with this RQI: T-1845-15, T-2525-15.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), nurse manager (NM), registered dietitian (RD), physiotherapist (PT), environmental services manager (ESM), minimum data set/resident assessment instrument (MDS/RAI) coordinator, quality improvement coordinator, business manager, resident & family relations coordinator, programs manager, resident care assistant/clerk, MDS/RAI coder, registered nursing staff, personal support workers (PSWs), residents, substitute decision makers (SDMs) and family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **10 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2014_159178_0024	178
LTCHA, 2007 S.O. 2007, c.8 s. 76.	CO #001	2015_370162_0003	162

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).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #04's written care plan (for an identified period in June and July, 2014) revealed that the resident was at high risk for falls and required an identified restraint while in his/her wheelchair.

A record review of the home's corresponding critical incident system (CIS) report revealed that the resident sustained a fall with an identified injury from his/her tilt wheelchair on an identified date and shift in July 2014. An interview with an identified PSW, who was assigned to the resident that shift, confirmed that he/she did not check to ensure that the resident's restraint was applied prior to the fall incident.

Further record review and an interview with the DOC revealed that the home later reviewed videotape footage of the incident and confirmed that the resident's restraint was not applied at the time of his/her fall. The DOC confirmed that since the resident's identified restraint was not applied, care was not performed as per the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change or the care set out in the plan is no longer necessary.

A review of resident #09's care plan revealed that he/she is identified as being at high

risk for falls. Further review revealed that the resident had fallen on two identified dates, two days apart in May 2015. The resident was sent to hospital the day after the second fall due to complaints of pain in two identified areas. The resident returned from hospital the next day with the diagnosis of an identified fracture.

Ongoing record review revealed that the resident's written care plan was not revised to include the identified falls prevention interventions recommended by the physiotherapist (PT) on the date of the resident's return from hospital. Furthermore, the written care plan was not revised to accurately reflect the resident's falls/balance problems and interventions regarding gait aids when the interventions were no longer necessary.

An interview with an identified member of the registered staff and the PT revealed that the care plan should have been revised when the resident's care needs changed or the interventions were no longer necessary. An interview with the DOC confirmed that the care plan was not revised to reflect the post-fall interventions when the resident's care needs changed. [s. 6. (10) (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 care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter.

Upon completion of the resident census record reviews during stage 1 of the Resident Quality Inspection (RQI), it was determined that 38 out of the 40 health care records in the sample did not have current heights taken for 2014.

The home's policy entitled Weight Management (#NMIIW015, effective January 2015) indicates that the RN/RPN will measure the resident's height and calculate the body mass index (BMI) on admission and annually.

Interviews with identified registered staff and the DOC revealed that heights are done on admission only. Staff were unaware that heights are to be measured annually thereafter. An interview with the registered dietitian (RD) confirmed that residents' heights are not taken annually. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter, to be implemented voluntarily.

WN #3: 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.

A record review of resident #04's current plan of care revealed that the resident has required use of an identified restraint while up in his/her wheelchair since an identified date in July 2014. Review of the resident's Restraint Flow Sheets revealed missing or undated documentation of all assessment, reassessment and monitoring, including the resident's response, for the following months: July-September 2014, December 2014, and January 2015. The nurse manager (NM) and MDS/RAI coordinator were unable to provide the resident's complete documentation records for his/her restraint monitoring. [s. 110. (7) 6.]

2. A review of resident #16's current plan of care revealed that the resident has required use of an identified restraint while up in his/her wheelchair since an identified date in October 2013.

An interview with an identified PSW revealed that there was no Restraint Flow Sheet being used to track resident #16's restraint monitoring checks for the month of June 2015, and confirmed that he/she had not been documenting the hourly restraint monitoring checks for the resident throughout the month of June.

A review of the resident's Restraint Flow Sheets revealed missing or undated documentation of all assessment, reassessment and monitoring, including the resident's response, for the following months: October-December 2013, February, May, and September 2014, January-April and June 2015. The NM and MDS/RAI coordinator were unable to provide the resident's complete documentation records for his/her restraint monitoring.

Staff interviews with the MDS/RAI coordinator, NM, and DOC confirmed that the home's expectation is for the residents' Restraint Flow Sheets to be completed hourly by the PSW staff, signed off every 8 hours by the registered staff, dated with the corresponding month, and filed in the resident's paper chart when complete. [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 #4: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered immunization against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A review of the home's RQI licensee confirmation checklist for infection prevention and control (IPAC) indicated that residents are not offered immunization against pneumococcus, tetanus and diphtheria.

Interviews with the home's lead for the IPAC program and the DOC confirmed that residents have not been offered immunization against pneumococcus, tetanus and diphtheria on admission or thereafter until recently. They both indicated that the process of obtaining consent for receiving immunization against pneumococcus, tetanus and diphtheria for residents has been undertaken, and immunizations will commence in July 2015. [s. 229. (10) 3.]

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 residents are offered immunization against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #5: 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 has failed to ensure that equipment is kept clean and sanitary.

Observations on June 17, 19, and 24, 2015, revealed that the wheelchairs used by residents #01 and #15 were not clean.

On June 19 and 24, 2015, resident #01's wheelchair was noted to be soiled with dried food residue on the left arm rest and on the top of the seat cushion. On June 24, 2015, interviews with an identified registered staff member and the home's NM both confirmed that resident #01's chair was soiled and required cleaning.

On June 17 and 24, 2015, resident #15's wheelchair was noted to be soiled with dried food residue on the footrests and on the side of the seat cushion. On June 24, 2015, interviews with an identified registered staff member and the NM both confirmed that resident #15's wheelchair was soiled and required cleaning.

Interviews with identified registered and non-registered staff, as well as the NM confirmed that the home has an identified company come in to deep clean the wheelchairs periodically, but that the front line staff are expected to clean the chairs in between deep cleaning, as needed. The NM stated that the front line staff cleans up small spills, but if there are a few dirty wheelchairs then the environmental staff will clean them.

An interview with the home's Environmental Services Manager (ESM) confirmed that the home has a contract with a company that comes in annually to deep clean all the wheelchairs, but in between, the environmental services department cleans the chairs when they are notified by nursing staff that cleaning is required. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care is based on an interdisciplinary assessment of the resident's vision.

A record review of the minimum data set (MDS) quarterly assessment from an identified date in December 2014, and the MDS annual assessment from an identified date in March 2015, indicated that resident #01 has identified vision problems. Both assessments indicated that the resident assessment protocol (RAP) would be care planned with the goal of maintaining the resident's current level of functioning. A review of the resident's written care plan revealed that a plan of care was not developed based on the assessments.

Interviews with identified registered staff members confirmed that a written care plan for vision was not in place for resident #01. An interview with the DOC confirmed that the RAP identifying interventions regarding the resident's vision should be included in the written plan of care. [s. 26. (3) 4.]

2. A record review of the MDS annual assessment from an identified date in December 2014, and quarterly review assessment from an identified date in March 2015, indicated that resident #16 has identified vision problems. Both assessments indicated that the RAP would be care planned with the goal of maintaining the resident's current level of functioning. A review of the resident's written care plan revealed that a plan of care was not developed based on the assessments.

Interviews with identified registered staff members confirmed that a written care plan for vision was not in place for resident #16. An interview with the DOC confirmed that the RAP identifying interventions regarding the resident's vision should be included in the written plan of care. [s. 26. (3) 4.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device is included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

A record review of resident #16's progress notes and Restraint Flow Sheets revealed that an identified restraint was initiated for the resident on an identified date in October 2013. Further review of the resident's health care record failed to reveal evidence of a doctor's order for the restraint. A review of the Valleyview quarterly restraint/PASD audit dated June 2015, left the column for "MD Order" unchecked for resident #16.

The NM and MDS/RAI coordinator were unable to provide evidence of an initial doctor's order for the restraint, and the NM reported that a call had been placed to the doctor to follow up and ensure an order was obtained.

Staff interviews with the MDS/RAI coordinator and DOC confirmed that the home's expectation is for an order from a physician or nurse in the extended class to be obtained prior to the implementation of a physical restraint. [s. 31. (2) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of written plans of care for resident #04 indicated that he/she was at high risk for falls in June/July 2014, and presently remains at high risk for falls. A review of the resident's progress notes revealed that resident #04 experienced four falls during the months of June and July 2014, on four identified dates, with two of the four falls leading to injuries. Two CIS reports were submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) related to the resident's falls on identified dates in June and July 2014, where the resident sustained identified injuries.

Record review and an interview with the MDS/RAI coordinator confirmed that the home's post-fall assessment tool (fall risk assessment), was not completed after the resident's falls on two of the identified dates in June and July, 2014. Interviews with the MDS/RAI coordinator and the DOC confirmed that, as per the home's policy, the fall risk assessment tool is to be completed after each fall incident whether or not an injury has been sustained. [s. 49. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A review of the MDS quarterly assessment from an identified date in December 2014, revealed that resident #01 was occasionally incontinent of bladder and had deteriorated in terms of urinary continence. The MDS annual assessment from an identified date in March 2015, revealed that the resident was frequently incontinent of bladder.

An interview with an identified member of the registered staff revealed that there were no continence assessments completed for this resident with his/her changes in continence level.

A review of the resident's health care record revealed that the resident has never received a continence assessment, including on admission, that includes all of the requirements set out in the legislation.

An interview with the lead for the continence care and bowel management program confirmed that a continence care assessment tool is to be completed on admission for every resident and when there is a change in the resident's urinary continence status. [s. 51. (2) (a)]

WN #10: 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 has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Observations on an identified unit on June 22, 2015, revealed that items other than drugs or drug-related supplies were stored in the narcotic drawer of the medication cart. The following non drug-related items were found stored within the narcotic drawer of the medication cart alongside a number of narcotics and controlled drugs:
- a television remote control
- a medic alert bracelet
- a broken key
- money in a clear bag labeled with a resident's name
- a silver bracelet
- a pair of eyeglasses
- digital pen refills, and
- a screw wrapped in a piece of paper.

An interview with the identified registered staff member on duty confirmed that these items were stored in the narcotic drawer, and stated that non drug-related items such as the above mentioned are sometimes stored there for safekeeping so they will not be misplaced.

An interview with the DOC confirmed that it is the home's protocol that only narcotics should be stored in the narcotic drawer. [s. 129. (1) (a)]

Issued on this 27th day of July, 2015

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

Original report signed by the inspector.