**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**


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

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 16, 2018 | 2017_631210_0021 | 016106-17, 024233-17, 025355-17 | Complaint |

## 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

SLAVICA VUCKO (210)

## 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): November 28, 29, 30, December 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 19, 2017**

**During this inspection the following complaints were inspected: #23541-17 from October 10, 2017 in relation to medication administration, personal care services, continence care, #25830-17 from November 14, 2017, in relation to personal care, infection prevention and control, #024233-17 from October 19, 2017 in relation to short staffing, personal care, continence care, hospitalization, #016106-17 from July 19, 2017 in relation to personal care services, dealing with complaints, #025355-17 from November 6, 2017 in relation to responsive behaviour.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Manager (RCM), Registered staff, Personal Support Workers (PSWs), Food Service Manager (FSM), Physiotherapist (PT), Family Council President, Residents’ Council President, Resident(s) and Substitute Decision Maker(s) (SDM). The inspector conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection prevention and control practices, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policy and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Medication**
**Personal Support Services**
**Reporting and Complaints**
**Responsive Behaviours**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
**7 WN(s)**
**3 VPC(s)**
**1 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 | Legendé<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 O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents’ assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. Licensee has failed to ensure that the staffing plan must
a) Provide for a staffing mix that is consistent with residents' assessed care and safety needs;
c) Promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage);
e) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Complaints were submitted to MOHLTC on identified dates in 2017, that baths were not provided to residents, the home was short of staff and medications were administered late on an identified date in 2017, evening shift.

a) A review of resident #006’s bath schedule revealed he/she was supposed to be provided shower on two specific days during the week. A review of the bath record revealed resident #006 was not provided shower during 5 occassions in two months in 2017. The staffing schedule for October and November 2017 revealed the following:

-on October 6, 2017 the short shift PSW from agency who was scheduled to work from 1700 to 2100 hrs did not show up at work, and was not replaced with another PSW,
-on October 7, 2017, the RN scheduled to work did not come to work and was not replaced; there were three RPNs at other units from staffing agency;
-on October 10, 2017, there were no PSWs scheduled from 1700 to 2100 hrs on two units and the schedule was empty; on another unit one PSW was from agency, and one full time,
-on October 17, 2017, the agency PSW who was scheduled to work from 1700 to 2100 hrs did not show up and was not replaced; another PSW on another unit from 1700 to 2100 was from the staffing agency
-on October 24, 2017, there was no short staff but the two PSWs from 1700 to 2100 hrs, were from the staffing agency;
-on November 3, 2017, the schedule was filled with PSWs, one PSW was from the staffing agency and he/she worked six hours combined on two units.

Interview with registered staff #117 and #100 revealed they were given direction from management when short staffed not to provide showers to residents.

c) During an interview with Resident Care Manager (RCM) #101) he/she was not able to clarify if the staffing back up plan was utilized and what was implemented in place when the unit was short of staff. During the above five shifts 17 different PSWs fulfilled the duties for the six scheduled or not scheduled PSWs.

A review of the staffing schedule revealed that on four units four part time PSWs are required to be scheduled from 1700 to 2100 hrs. An interview with the scheduling clerk Staff #118 revealed if the schedule is sent to units with no staff scheduled, it means that he/she was not able to fill in with the full or part time staff from the home nor from the staffing agency and the units were to work short staffed. The schedule is created at least five days in advance and management knows that the units would be working short of staff on those days (on October 10, 2017).

A review of the policy Short Staffing Management, #NMIIS036vv, from January 1, 2016, revealed in the event that a PSW is not available to work on any given shift, the following process is to be initiated: the Registered Staff managing the short staffed unit will liaise with the Nurse in Charge of the facility to re-allocate PSW staff and duties to provide resident care and services that are essential to resident well- being. The Nurse in Charge will attach the completed staffing reallocations /management plan –Adjusted Registered Staffing Template used, on the back of the Daily Staffing Roster for the date/shift

affected.

A review of the staffing schedule for October 7, 2017, revealed one unit was short of an RN. According to the policy Short Staffing Management, NMIIS036vv, from September 5, 2017, if a unit is short of a registered staff, the registered staff from other units will be allocated to help, and an extra PSW will be called in to work on the unit that is short staffed. On the staffing schedule for October 7, 2017, was written by hand that an extra PSW was required on the unit but there was no name on the schedule that a PSW was allocated.

Interview with DOC revealed the PSW positions 1700 to 2100 hrs on four units are not filled in with permanent staff because the home has hard time to hire permanent PSWs. According to DOC, when the home is not able to place staff on units according to schedule, the home has to work short of staff. PSWs are not interested in taking a part time line and the home fills in the staff with different PSWs that are available, either from the home part time staff or the two staffing agencies. In December 2017 the home hired a third staffing agency to fill in the staffing shortage. In 2017 the home interviewed 57 PSWs and hired only 14 PSWs because the others were not able to answer the interview questions about abuse reporting. According to DOC the home still requires total of 18 part time PSW positions.

An interview with the Administrator revealed that the home was thinking about exploring options about different assignment of PSWs duties, such as the showers, and creating full time PSW positions instead of part time, but this was never officialised in a staffing evaluation process.

d) An interview with the home's Administrator revealed the home is not able to provide to the inspector an evaluation of the staffing plan for 2016 because the home did not do it. The evaluation of the 2015 staffing plan and interview with the Administrator revealed the staffing plan was created according to Case Mix Index (CMI) which indicates the level of residents' care needs.

The home was issued compliance order #2016_378116_0012 on January 12, 2017, with a due date February 24, 2017, to develop and implement staffing strategy to ensure residents are monitored for assisting with required care needs according to their plan of care. In one of the findings a PSW (Staff #140) from staffing agency provided care to a resident. The home submitted a compliance plan to the inspector that the home will review the staffing plan, and explore for opportunities to increase staffing. During the

follow up inspection of the order the home was not able to provide proof that the home reviewed the staffing plan for 2016 according to the compliance plan.

A review of the Resident Council meeting from December 19, 2016, revealed a concern of short staffing on units. On December 20, 2016, the minutes from Management Committee revealed that management works to utilize its part time staff and has an agreement with two staffing agencies to supplement Valleyview workforce, however from time to time staffing shortages may occur due to lack of available staff (internal and agency).

A review of the staffing plan and schedule, the residents' care needs, the staffing back-up plan, the policy for Nursing Staffing Plan and Short Staffing Management, interviews with registered staff, PSWs, RCM, DOC and Administrator confirmed that the staff schedule was not filled in with staff according to evaluated Case Mix Index (CMI) which indicates residents' assessed care needs. The different staff who provided nursing and personal support services to each resident scheduled on units did not promote continuity of care by minimizing the number of different staff members. There was no evidence that the back-up plan/policy for nursing and personal care staffing was implemented in practice when staff cannot come to work and the staffing plan was not evaluated and updated for 2016.

Severity of the non-compliance and severity of the harm was potential for harm. The scope of the non-compliance was pattern. [s. 31. (3)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Complaints were submitted to MOHLTC on two ocassions that the home was short of staff on October 7, 2017.

A review of the home's resident list of currently admitted residents indicated there are 170 residents in the home.

A review of the staff schedule for October, November and December 2017, revealed on October 7, 2017 evening shift and October 27, 2017 night shift, there was no registered nurse on duty. Interview with staff #118 revealed if the home is not able to find replacement for staff the units have to work short staff and implement the back up plan. He/she indicated that on October 7, 2017, two Registered Practical Nurses (RPN) were appointed to be in charge of the home.

A review of the policy Nursing Manual 2017, Nursing Staffing Plan, NMIIN035 from September 1, 2017, revealed the DOC will ensure that an RN employed by the home and a member of the regular nursing staff is on duty in the home 24 hours per day, 7 days per week, not including the administrator or director of resident care.

Interview with DOC confirmed that there was no registered nurse on October 7 and 27, 2017 because the registered nurses who were scheduled to work on those shifts were not able to come to work and called last minute. [s. 8. (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 there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to MOHLTC on that resident #006 missed showers, the home was short of staff, the resident was washed instead of showered.

Interview with a resident # 006's family member indicated the resident loves showers and he/she is not aware that the resident refuses showers. The family member indicated that the resident is prone to a specific health status and that is why he/she considered the showers very important to him/her. The resident was treated for the specific health status three times during two months in 2017.

According to the bath schedule resident #006 was supposed to be provided showers two times a week. A review of the bath record indicated the resident was not provided baths on five occasions in two months. Interview with registered staff #100 and #117 revealed that if the unit is short of PSWs then the home would not provide baths, and will try to make it up the following day when there is sufficient staff.

A review of the Bathing Policy, # NMIIB005, dated August 30, 2017, revealed each resident will be bathed at least twice a week, unless medically contraindicated, or is against the wishes of the resident. Bathing method (e.g.: tub bath, sponge bath, shower) will depend on the resident's choice and the frequency will be determined by his or her hygiene requirements. The PSW bathing the resident will report to the charge nurse if the resident refuses to be bathed and will record on the flow sheet the care provided.

Interview with Resident Care Manager staff #101 indicated the bathing requirements according to the policy and after the review of the flow sheets confirmed resident #006 was not provided with bath two times a week during the identified period in 2017. [s. 33. (1)]

***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 is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that that a documented record is kept in the home that includes: the nature of each verbal or written complaint, the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

A complaint was submitted to MOHLTC by a family member that resident #006 was not

provided shower on a specific day, the home is short of staff, and the home did not respond to his/her complaints.

Interview with resident #006's family member revealed on a specific date, shower was not provided to resident #006 and the assigned PSW staff was from staffing agency.

An interview with DOC revealed the family member of resident #006 left a voice message on a specific date, in regards to frequency of showers. Because she was not in the office she forwarded the message to the Nurse Manager. According to the Nurse Manager interview he/she left a message to the complainant to call her back. A review of the resident #006's bathing record revealed the resident was not provided showers on five occasions during two months in 2017. During the interview the Nurse Manager indicated that he/she did not remember the content of the message he/she left to the complainant. She indicated that during a later conversation with the complainant in regards to resident #006's showers he/she responded to the complainant that the home does not provide showers on Saturday, and that the family member was not satisfied with the outcome of the discussion.

A review of the Concerns and Complaints policy, ADM-07-035, from January 2017, indicated complaints must be documented on the "Incident Notes" in Mede-care if they are resident related. The documentation should include the date the information was received, the service involved, a list of the issues reviewed, the details and date of any follow up action taken, a description of any final resolution and the details and date of the feedback provided to the client. For those complaints that cannot be investigated and resolved within 10 business days, the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 5 shall be provided as soon as possible in the circumstances. A response shall be made to the person who made the complaint, indicating, what Valleyview has done to resolve the complaint, or Valleyview believes the complaint to be unfounded and the reasons for the belief. Valleyview will ensure that a documented record is kept and will include the following: the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of action, time frames for actions to be taken and any follow up action required, the final resolution, if any; every date which any response was provided to the complainant and a description of the response; any response made in turn by the complainant.

Interview with Staff #116, the Quality Improvement (QI) lead, revealed he/she is responsible for analyzing the complaints, but the particular complaint for resident #006's

showers was never submitted to him/her.

Interview with the Administrator revealed that the home documents the complaints in the progress notes of the electronic resident's chart and there is a privacy issue if the complaints are documented in progress notes, that is why not all complaints are documented. Interview with the Nurse Manager revealed indicated he/she did not document the details nor the outcome of the conversation with resident #006's family member about the frequency of showers because he/she considered it as a discussion with the family member not as a complaint. [s. 101. (2)]

***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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately, to be implemented voluntarily.***

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**WN #5: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

A review of the policy Nursing Manual 2017, Nursing Staffing Plan, from September 1, 2017, revealed in the event that a Registered Staff member is not available to work on any given unit on the day shift or evening shift the Nurse in Charge of the Facility shall reallocate the administration of medication and treatments between remaining five Registered Staff in the facility. The DOC will ensure that a RN employed by the home and a member of the regular nursing staff is on duty in the home 24 hours per day, 7 days per week, not including the administrator or DOC. In the case of an emergency (emergency means an unforeseen situation of a serious nature that prevents an RN from getting to the long-term care home) where the back up plan fails, a RN who works at the home according to a contract or agreement between the home and an employment agency may be used if the DOC or a RN who is both an employee of the home and a member of the regular nursing staff is available by telephone or a RPN who is a member of the regular nursing staff may be used if the DOC or a RN who is both a member of the regular nursing staff both is available by telephone.

Interview with DOC revealed the home is aware about the requirement of RN to be on duty 24 hours per day, 7 days per week. The back up plan for nursing did not address situations when RN who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work. DOC indicated when an RN calls in sick, and there are no RNs available to replace, there is nothing the home can do about it and they can implement the back up plan for RN that applies for emergency. The home's policy for the requirement of a registered nurse 24/7 in the home was contradictory with this requirement. [s. 8. (1) (b)]

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**WN #6: 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 the resident who is incontinent has received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Complaints were submitted to MOHLTC in 2017, that resident # 006 was not provided care on a regular basis and as required.

A review of resident #006's clinical record revealed the resident was admitted on a specified date. His/Her initial continence assessment indicated he/she was continent of bladder and bowels. The Minimum Data Set (MDS) assessment on a specified date in 2017, revealed the resident was incontinent of bladder and bowel. A review of the written plan of care revealed staff to ask resident for toileting, continent product to be applied as required. Interview with PSW #103 revealed resident #006's was provided personal care at scheduled times and when necessary.

A review of the resident worksheet for continent products revealed resident #006 to be provided personal care once per shift. Interview with RCM staff #101 revealed the expectation is staff to monitor the resident and provide care at identified times.

Interview with registered staff #100 revealed residents' continence status is assessed on the special electronic continence assessment form at admission and annually. A review of the Continence care -Bladder and Bowel, NRS-03-091, from November 2016, indicated the registered staff will reassess resident's continence status annually at a minimum and as needed. Interview with registered staff #100 confirmed resident #006's continence was not assessed on a specified date on the continence assessment form with causal factors, patterns, type of incontinence and potential to restore function with specific interventions, when his/her continence status changed from continent to incontinent. [s. 51. (2) (a)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Complaints were submitted to MOHLTC on October 10 and 19, 2017, indicating that the home was short of staff and medications were administered late.

A review of the electronic medication record (eMAR) for resident #006 on a specified date, revealed that a specific test was ordered to be performed specific number of times a day, and it was documented that it was checked several times; the administration of a specific medication was not signed as administered, and another specific medication was signed at 2114 hrs as administered by the registered nurse Staff #123.

Interview with registered staff RPN #123 revealed he/she helped with medication administration on a specific date. Interview with registered staff from agency RPN #119 revealed on a specific date he/she was scheduled to work on another unit and had to help at the other unit with medication administration as they were short of registered staff.

Interview with registered staff RPN #123 revealed that expectation is when medications are to be administered, first they need to be checked in the pouch and verified with the resident order, and once they are administered to a resident they are to be signed in the electronic medication administration record (eMAR) at the moment of administration. He/She confirmed that resident #006 had two specific medications to be administered at specific times but was not able to confirm that they were administered on time. [s. 131. (2)]

**Issued on this 13th day of February, 2018**

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

**Original report signed by the inspector.**

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

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | SLAVICA VUCKO (210) |
| **Inspection No. / No de l'inspection :** | 2017_631210_0021 |
| **Log No. / No de registre :** | 016106-17, 024233-17, 025355-17 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jan 16, 2018 |
| **Licensee / Titulaire de permis :** | ADVENT HEALTH CARE CORPORATION<br>541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3 |
| **LTC Home / Foyer de SLD :** | VALLEYVIEW RESIDENCE<br>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:

**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. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
O. Reg. 79/10, s. 31 (3).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that the staffing plan provide for a staffing mix that is consistent with residents assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

The plan will include, at a minimum, the following elements:

1. A hiring plan that ensures the home has all vacant staff positions filled and a sufficient casual/part-time staffing pool in place in six months,
2. An alternate staffing plan that ensures the home is staffed appropriately while implementing their hiring plan and that the alternate staffing plan includes education in the home's practices related to resident care,
3. A documented monitoring system to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice when short staffed and that also includes alternate baths/shower days when not provided as per their plan of care,
5. Collaboration methods of management staff and scheduling clerk in realization of the staffing plan
6. Conduct an evaluation of the home's staffing plan and update at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices.
7. Maintain a record of the annual staffing plan review.

Please submit the plan to Slavica Vucko at slavica.vucko@ontario.ca by January 31, 2018

**Grounds / Motifs :**

1. Licensee has failed to ensure that the staffing plan must
a) Provide for a staffing mix that is consistent with residents' assessed care and safety needs;
c) Promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage);
e) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Complaints were submitted to MOHLTC on identified dates in 2017, that baths were not provided to residents, the home was short of staff and medications

were administered late on an identified date in 2017, evening shift.

a) A review of resident #006's bath schedule revealed he/she was supposed to be provided shower on two specific days during the week. A review of the bath record revealed resident #006 was not provided shower during 5 occasions in two months in 2017. The staffing schedule for October and November 2017 revealed the following:
-on October 6, 2017 the short shift PSW from agency who was scheduled to work from 1700 to 2100 hrs did not show up at work, and was not replaced with another PSW,
-on October 7, 2017, the RN scheduled to work did not come to work and was not replaced; there were three RPNs at other units from staffing agency;
-on October 10, 2017, there were no PSWs scheduled from 1700 to 2100 hrs on two units and the schedule was empty;  on another unit one PSW was from agency, and one full time,
-on October 17, 2017, the agency PSW who was scheduled to work from 1700 to 2100 hrs did not show up and was not replaced; another PSW on another unit from 1700 to 2100 was from the staffing agency
-on October 24, 2017, there was no short staff but the two PSWs from 1700 to 2100 hrs, were from the staffing agency;
-on November 3, 2017, the schedule was filled with PSWs, one PSW was from the staffing agency and she worked six hours combined on two units.

Interview with registered staff #117 and #100 revealed they were given direction from management when short staffed not to provide showers to residents.

c) During an interview with Resident Care Manager (RCM) #101) he/she was not able to clarify if the staffing back up plan was utilized and what was implemented in place when the unit was short of staff. During the above five evening shifts on 17 different PSWs fulfilled the duties for the six scheduled or not scheduled PSWs.

A review of the staffing schedule revealed that on four units four part time PSWs are required to be scheduled from 1700 to 2100 hrs. An interview with the scheduling clerk Staff #118 revealed if the schedule is sent to units with no staff scheduled, it means that he was not able to fill in with the full or part time staff from the home nor from the staffing agency and the units have to work short staffed. The schedule is created at least five days in advance and management knows that the units will be working short of staff on those days (on October 10,

2017).

A review of the policy Short Staffing Management, #NMIIS036vv, from January 1, 2016, revealed in the event that a PSW is not available to work on any given shift, the following process is to be initiated: the Registered Staff managing the short staffed unit will liaise with the Nurse in Charge of the facility to re-allocate PSW staff and duties to provide resident care and services that are essential to resident well- being. The Nurse in Charge will attach the completed staffing reallocations /management plan –Adjusted Registered Staffing Template used, on the back of the Daily Staffing Roster for the date/shift affected.

A review of the staffing schedule for October 7, 2017, revealed one unit was short of an RN. According to the policy Short Staffing Management, NMIIS036vv, from September 5, 2017, if a unit is short of a registered staff, the registered staff from other units will be allocated to help, and an extra PSW will be called in to work on the unit that is short staffed. On the staffing schedule for October 7, 2017, was written by hand that an extra PSW was required on the unit but there was no name on the schedule that a PSW was allocated.

Interview with DOC revealed the PSW positions 1700 to 2100 hrs are not filled in with permanent staff because the home has hard time to hire permanent PSWs. According to DOC, when the home is not able to place staff on units according to schedule, the home has to work short of staff. PSWs are not interested in taking a part time line and the home fills in the staff with different PSWs that are available, either from the home part time staff or the two staffing agencies. In December 2017 the home hired a third staffing agency to fill in the staffing shortage. In 2017 the home interviewed 57 PSWs and hired only 14 PSWs because the others were not able to answer the interview questions about abuse reporting. According to DOC the home still requires total of 18 part time PSW positions.

An interview with the Administrator revealed that the home was thinking about exploring options about different assignment of PSWs duties, such as the showers, and creating full time PSW positions instead of part time, but this was never officialized in a staffing evaluation process.

d) An interview with the home's Administrator revealed the home is not able to provide to the inspector an evaluation of the staffing plan for 2016 because the home did not do it. The evaluation of the 2015 staffing plan and interview with

the Administrator revealed the staffing plan was created according to Case Mix Index (CMI) which indicates the level of residents' care needs.

The home was issued compliance order #2016_378116_0012 on January 12, 2017, with a due date February 24, 2017, to develop and implement staffing strategy to ensure residents are monitored for assisting with required care needs according to their plan of care. In one of the findings a PSW (Staff #140) from staffing agency provided care to a resident. The home submitted a compliance plan to the inspector that the home will review the staffing plan, and explore for opportunities to increase staffing. During the follow up inspection of the order the home was not able to provide proof that the home reviewed the staffing plan for 2016 according to the compliance plan.

A review of the Resident Council meeting from December 19, 2016, revealed a concern of short staffing on units. On December 20, 2016, the minutes from Management Committee revealed that management works to utilize its part time staff and has an agreement with two staffing agencies to supplement Valleyview workforce, however from time to time staffing shortages may occur due to lack of available staff (internal and agency).

A review of the staffing plan and schedule, the residents' care needs, the staffing back-up plan, the policy for Nursing Staffing Plan and Short Staffing Management, interviews with registered staff, PSWs, RCM, DOC and Administrator confirmed that the staff schedule was not filled in with staff according to evaluated Case Mix Index (CMI) which indicates residents' assessed care needs. The different staff who provided nursing and personal support services to each resident scheduled on units did not promote continuity of care by minimizing the number of different staff members. There was no evidence that the back-up plan/policy for nursing and personal care staffing was implemented in practice when staff cannot come to work and the staffing plan was not evaluated and updated for 2016.

Severity of the non-compliance and severity of the harm was potential for harm. The scope of the non-compliance was pattern. [s. 31. (3)] (210)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 31, 2018

## 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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

| | |
|---|---|
| À l'attention du/de la registrateur(e)<br>151, rue Bloor Ouest, 9e étage<br>Toronto ON  M5S 2T5 | Directeur<br>a/s du coordonnateur/de la coordonnatrice en matière d'appels<br>Direction de l'inspection des foyers de soins de longue durée<br>Ministère de la Santé et des Soins de longue durée<br>1075, rue Bay, 11e étage<br>Toronto ON  M5S 2B1<br>Télécopieur : 416 327-7603 |

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 16th day of January, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector / Nom de l'inspecteur :** Slavica Vucko

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