Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8ième étage
Toronto, ON M4V 2Y7

Téléphone: 416-325-9297
1-866-311-8002

Télécopieur: 416-327-4486

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 25, 31, 2011	2011_116_2954_31_Jan105439	Critical Incident

Licensee/Titulaire

Advent Healthcare Corporation

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

Valleyview Residence, 541 Finch Avenue West, Toronto ON, M2R 3Y3

Name of Inspector/Nom de l'inspecteur

Saran Daniel-Dodd, Nursing Inspector

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Assistant Director of Care, Registered staff and frontline staff members.

During the course of the inspection, the inspector: Reviewed the homes medication administration policy 8-1, reviewed medication administration records of 13 identified residents,
The following Inspection Protocols were used in part or in whole during this inspection:
Critical Incident
Medication

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
1 VPC

NON-COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.
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.)	Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg. 79/10 s.107 (4)1. A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

Findings:

1. **On August 24, 2010, an incident involving medications not being administered to 13 residents was communicated to a registered staff member of the home.**
2. **The licensee did not report the incident to the Director until September 22, 2010 (21 days after the incident).**

Inspector ID #:	116

WN #2: The Licensee has failed to comply with O.Reg. 79/10 s. 131 (2). The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Findings:

1. **On July 31, 2010, a registered staff member did not administer scheduled evening dose of prescribed medications to 13 residents.**
2. **On August 13, 2010, three residents did not receive scheduled evening medications as prescribed by the physician.**

The registered staff member resigned from the home on September 22, 2010.

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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 regarding ensuring medications are administered to all residents as per the directions specified by the prescriber.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). March 24, 2011