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 prévue 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 6, 2019	2019_641665_0011	007908-18, 008015-18, 018391-18, 026129-18	Critical Incident System

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

JOY IERACI (665), GORDANA KRSTEVSKA (600), NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 21, 22, 23 and 24, 2019.

The following critical incident system (CIS) intake logs were inspected:
- Log # 007908-18/CIS #2954-000003-18 related to transferring and positioning
- Log #008015-18/CIS #2954-000005-18 related to staff to resident neglect
- Log #018391-18/CIS #2954-000013-18 related to staff to resident abuse
- Log #026129-18/CIS #2954-000028-18 related to plan of care

The inspection for Logs #008015-18 and #018391-18 were documented in a concurrent follow up inspection #2019_641665_0010.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Quality Improvement Coordinator (QIC), Resident Care Manager (RCM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW) and residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 VPC(s)
0 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	Légende 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).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided by PSW #115 to resident #054 as specified in the plan.

The home submitted a CIS report to the Ministry of Health and Long Term Care (MOHLTC), for an incident that occurred on an identified date in 2018. The CIS report indicated that resident #054 had an unwitnessed fall with injury while the resident had an identified intervention to manage their responsive behaviour. The home reviewed their video surveillance and observed PSW #115 in the nursing station at the time of the fall.

A review of the responsive behaviour written plan of care effective 19 days prior to the critical incident, indicated that resident #054 had the identified intervention noted above to manage their responsive behaviour.

In an interview, PSW #115 indicated they were the assigned PSW who provided the identified intervention for resident #054 at the time of the critical incident. PSW #115 stated that when a resident had the identified intervention, they were not to leave the resident alone. The PSW said that they had left the resident alone for a specified period of time to complete documentation and online education in a specified location of the resident home area. PSW #115 confirmed they did not follow the plan of care for resident #054, as they left the resident alone when the fall occurred.

In an interview, the ED indicated that residents who have the identified intervention, the assigned PSW must be with the resident at all times and must inform the registered staff if they need to leave the resident. The ED indicated that the home conducted an investigation and reviewed their video surveillance, which indicated that PSW #115 left the resident for a period of time. The ED acknowledged that PSW #115 failed to ensure that the care set out in the plan of care was provided to resident #054 as specified in the plan.

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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that PSW #113 used safe transferring techniques when assisting resident #031.

The home submitted a CIS report to the MOHLTC on an identified date in 2018, regarding an injury to resident #031 that resulted in a significant change in the resident's health status.

A review of the amended CIS report and the resident's progress notes indicated that on the identified date noted above, PSW #112 provided care to resident #031, and observed two areas of altered skin integrity on the resident's body.

Review of the resident's resident assessment instrument - minimum data set (RAI-MDS) assessment and written plan of care indicated that the resident needed total assistance with transfers using a specified device by an identified number of staff members.

A review of the home's investigation indicated that the day prior to the submission of the CIS, PSW #113 had assisted resident #031 with a transfer using the specified device. Further review of the investigation indicated that the PSW used the specified device alone which raised concerns to the home that the PSW did not comply with their safe transfer policy which may have caused the injury to resident #031.

In an interview, PSW #113 indicated that they provided care to resident #031 and transferred the resident. The PSW confirmed that they used the specified device to transfer the resident alone as the unit was short of staff and the other PSW was providing care to another resident.

In an interview, the DRC confirmed PSW #113 transferred the resident using the specified device by themselves. The DRC acknowledged that PSW #113 did not use safe transferring techniques when assisting resident #031's transfer with the specified device.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to report to the Director the results of the investigation undertaken for an identified CIS report.

The home submitted a CIS report on an identified date in 2018, related to staff to resident neglect towards resident #054.

A review of the CIS report indicated that it was amended on three identified dates, indicating that the investigation was in progress. At the time of the inspection, there were no other amendments made to the CIS report with the outcome of the investigation.

In an interview, the ED indicated that the home conducted an investigation of the critical incident. The ED reviewed the CIS report and acknowledged that the CIS report should have been amended with the outcome of the investigation.

Issued on this 7th day of June, 2019

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

Original report signed by the inspector.