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

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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_766500_0014	007691-19	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

NITAL SHETH (500)

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): May 21, 22, 23, 24, 2019.

The complaint intake log #007691-19 related to the home neglecting the resident was inspected during this inspection.

A non-compliance identified under s. 19 (1) for resident #005, during concurrent Follow-up (F/U) inspection # 2019_641665_0010 is issued in this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physician, Registered Nurse (RN) Clinical Support, and Registered Nurses (RNs).

During the course of the inspection, the inspector reviewed the resident's records, and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #055 and #056 that sets out, the planned care for the residents' advance directives for Cardio-Pulmonary Resuscitation (CPR) and hospitalization.

A complaint was received by the Ministry of Health and Long-term Care (MOHLTC) indicated that the home neglected resident #055 and took more than two hour to send them to the hospital while waiting for the physician to arrive. The resident passed away while the paramedics were preparing them for the ambulance.

- A review of the resident #055's initial Medical Data Sheet (MDS) and quarterly assessment completed on an identified day, indicated that the resident's advance directive for not hospitalizing and not resuscitating were not place.

A review of the resident #055's clinical record indicated that there was no advance directive in place for resuscitation, and hospitalization. The inspector found a CPR form made at the different facility.

-A review of resident #056's MDS assessment completed on an identified day, indicated that the resident's advance directives for Do Not Resuscitating (DNR) and hospitalization were not in place.

A review of the resident #056's chart indicated that the form for DNR form was not available in the chart.

A review of the resident #056's progress notes did not indicate the information about the resident's DNR/ CPR.

Interview with Registered Nurse (RN) #106 indicated that the home did not have an advance directive for residents, however the home has only CPR forms available for the residents.

A review of the home's policy #NM-II-C005, entitled, "Cardio-Pulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR), dated January 2017, indicated that RN, RPN, NP or physician will identify and document the resident's wishes, if known, with respect to CPR and include the information in the resident's plan of care.

Interview with the Clinical Support RN and Director of Care (DOC) indicated that the resident should have CPR information in their plan of care and it should be updated annually. [s. 6. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, the planned care for the residents' advance directives for Cardio-Pulmonary Resuscitation (CPR) and hospitalization, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #055 was not neglected by the licensee or staff.

For the purposes of the definition of "neglect" in subsection 2 (1) of the O. Reg. 79/10, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was received by the MOHLTC, indicated that the home neglected resident #055 and took more than two hours to send them to the hospital, while waiting for the physician to arrive. The resident passed away, when the paramedics were preparing them for an ambulance.

Interview with the resident #055's Substitute Decision Maker (SDM) indicated that the staff in the home kept informing them that they were waiting for the physician's order to transfer the resident to the hospital. The SDM indicated that it took approximately two hours for the home to call paramedics. During this time frame, the resident was left in the room in their bed, with their family member. No staff went into the resident's room during this two hours of time period to observe the resident. The SDM indicated that the home neglected the resident, the resident had to suffer, as the home did not look after the resident properly. The staff members kept telling them that the resident was okay. The resident passed away when the paramedics were preparing to transfer the resident in the ambulance.

A review of the resident's progress note indicated that the Personal Support Worker (PSW) reported to RN #108 that the resident had a change in their health condition. RN #108 assessed the resident and implemented an identified intervention. RN #108 called physician #101, the physician indicated that if family agrees send the resident to the hospital and call them back. RN #108 called the family, and the family member agreed to send the resident to the hospital. RN #108 called the physician and left a voicemail to receive an order to send the resident to the hospital. Meanwhile, the family arrived to the home, the physician was paged and left a voicemail. RN #107 called physician #002 to get the order, however, received an autoreply that the physician was on vacation. RN #107 and #108 called the DOC to explain the situation, and DOC directed them to call another physician #003. RN #107 called physician #003 and left a voicemail. In five minutes, RN #107 was able to obtain an order from physician #003 to send the resident to the hospital. The resident was send to the hospital with paramedics and the family member, in two hours of time period since the family agreed to send the resident to the hospital. Later, the paramedics called the home and informed that the resident passed away at the long-term care home and brought back to the room.

The inspector was unable to complete interviews with RN #108.

Interview with RN #107 indicated, that RN #108 endorsed to them that they were waiting for physician's orders to transfer the resident to the hospital, and the physician was not reachable. RN #107 confirmed that they do not require a physician's orders to transfer the resident to the hospital, and the resident's health was at risk during the wait time. RN #107 confirmed that RN #108 indicated that the resident needed to be transferred to the hospital.

Interview with RN #106 who works regularly on the floor, indicated that the staff do not

require a physician's order to send the resident to the hospital. RN #106 reviewed the progress notes and indicated that they should have proceeded with hospital transfer and call the physician later once the family agreed.

Interview with Physician #101 indicated that the resident should have been sent to the hospital as the order was already given to the staff, if the family agrees, and the staff did not require a physician's order to send the resident to the hospital in an emergency situation.

A review of the home's policy, entitled, "Emergency Services Manual", dated January 2016, defined "Medical Emergency" as an event requiring the rapid assessment and intervention of trained medical personnel which may include but is not limited to serious injury, unconsciousness, serious respiratory symptoms, and symptoms of cardiac crisis.

Interview with the Clinical Support RN and DOC indicated that the resident was neglected for two hours, when the staff neglected to send out to the hospital while waiting for the physician's orders, when there was significant change in their health condition and the resident's heath was jeopardized.

This non-compliance was issued as the staff waited for more than two hours to receive an order from the physician to transfer the resident to the hospital, which was not required considering the resident's emergency medical condition, which jeopardized the resident's health. In addition, the resident did not receive any monitoring and reassessments during this wait time. [s. 19. (1)]

2. The licensee has failed to ensure that resident #005 was protected from abuse by PSW #107.

MOHLTC received a Critical Incident System (CIS) report from the home related to staff to resident abuse. The CIS indicated resident #005's SDM reported to the home that PSW# 107 regularly berates resident #005 and has engaged in aggressive care when resident #005 asked PSW #107 to stop being so rough.

Under O. Reg. 79/10, s.2 for the purpose of the definition of "verbal abuse" in subsection 2 of the Act, " verbal abuse" means any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth made by anyone other than a resident.

Record review of the licensee's investigation notes indicated the nurse mangers (NM) interviewed PSW #107 and they admitted that they were sorry and did not intentionally verbally abuse resident #005. NMs directed PSW #107 to read and sign the abuse policy, to no longer provide care for resident #005 and they also received disciplinary actions.

Record review of PSW #107 disciplinary notice indicated, it was observed through a video recording provided by the family to the home which verified PSW #107 demonstrated actions of verbal abuse towards resident #005. This notice also indicated the PSW demonstrated inappropriate and unprofessional behaviour, in which PSW #107 verbally communicated to resident #005 in an intimidating and belittling nature, which diminished the resident sense of well-being, dignity and self-worth.

Review of the video recordings of PSW #107 providing care to resident #005 indicated that in the three identified video recordings, PSW #107 was verbally abuse to resident #005 and did not treat resident #005 with dignity and respect.

PSW #107 was on a leave during the inspection and could not be interviewed.

DOC #104 and Administrator #111 both confirmed PSW #107 verbally abused resident #005 and received disciplinary actions. [s. 19. (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 protect residents from abuse by anyone to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 10th day of June, 2019

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

Original report signed by the inspector.