Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 21, 2019	2019_526645_0015	018052-19, 018110-19	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

DEREGE GEDA (645)

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): October 16, 17, 18, 21, 22, 23, 24 and 25, 2019.

The following critical incidents with log# 018052-19 (#2954-000029-19) related to safe and secure home and log# 018110-19 (#2954-000030-19) related to prevention of abuse and neglect, were inspected.

Two Voluntary Plan of Correction related to LTCHA,2007, c.8, s. 49(2) and 48(1)4, identified in a concurrent complaint inspection #2019_526645_0014 (Log # 015886-19), are issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse manager (NM), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Residents.

During the course of the inspection, the inspector performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, medication administration records (MAR), staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

7 WN(s)
6 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

A Critical Incident Sysytem (CIS) was received by the Ministry of Long Term Care (MLTC), regarding improper/incompetent treatment and abuse of resident #003 by staff members. The report indicated that RN #101 forcefully pulled the resident and caused them to fall.

Inspector #645 reviewed the video surveillance footage. The video footage indicated the RN physically abused the resident. Throughout the footage, the resident was naked below the waist. Staff members were also observed undressing the resident in the hallway without providing privacy.

Interview with the DOC indicated that throughout the video the resident was partially naked and soiled, and staff was observed undressing the resident in the hallway without providing privacy. The action of the staff was in violation of the home's zero tolerance of abuse and neglect, and the Residents' Bill of Rights and Dignity policy. The DOC reiterated that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]

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 following rights of residents are fully respected and promoted: 1. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, 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 #003 was protected from abuse and neglect.

Under O. Reg. 79/10, s. 2, for the purposes of the Act and Regulations, "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 wellbeing of one or more residents.

A CIS was received by the MLTC regarding improper/incompetent treatment and abuse of resident #003 by staff members. The report indicated that the home witnessed the incident of abuse through video surveillance footage, while conducting an unrelated investigation, and notified the Ministry immediately. The report indicated that RN #101 forcefully pulled the resident and caused them to fall.

Record review of the home's investigation note indicated that the home contacted the police immediately and the RN was suspended pending investigation. The review of the disciplinary letter on an identified date indicated that the home determined the action of the nurse as abuse.

A review of the video surveillance footage indicated the action of the RN, which constituted physical abuse.

Inspector was unable to interview RN #101 as they were not available.

Interview with the DOC confirmed that RN #101 forcefully pulled resident #003 causing them to fall. The DOC indicated that the resident was at high risk for fall and leaving the resident unattended after they fell was unacceptable. They indicated that the action of the nurse was in violation of the home's zero tolerance of abuse and neglect policy. They confirmed that RN #101 neglected the resident, and jeopardized their well being as they failed to provide care and assistance required for the health and safety of the resident. [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 and ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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 home's clinically appropriate fall-assessment tool was used to assess the resident.

A complaint was received by the MLTC regarding resident #002. The complainant stated that resident #002 had a fall and was hospitalized.

Record review of the progress notes indicated that resident #002 had a fall on an identified date. The notes indicated that the resident was limping following the fall incident and few days later, the facility physician diagnosed them with injury of the identified body part. The notes indicated that, a week later, the resident was unable to ambulate, and complained of severe pain. On the same day, the resident was hospitalized for treatments and returned to the home two weeks after the identified date.

The home's policy titled " Fall-prevention and Management, #NMIIF005" last reviewed on January 2019, states that when a resident has fallen, registered staff should complete the following: Fall risk assessment, head to toe and skin assessment, complete Head Injury Routine (HIR) if injury to the head is suspected; complete an internal incident

report and conduct a thorough post fall investigation and identify contributing factors. Further review of the records did not indicate if post fall assessment was completed following the fall incident.

An interview with RN #100 confirmed that there was no post fall assessment completed following the fall incident. RN #100 indicated that they only completed a head to toe assessment few days later, after the resident had difficulty ambulating. Interview with the RAI-MDS coordinator also indicated that there was no post fall assessment completed following the fall.

Inspector #645 reviewed two additional fall incidents for residents #001 and #003, to increase the residents sample due to identified noncompliance.

A). Review of the progress notes on an identified date indicated that resident #001 had a fall. Review of the records did not indicate if a post fall assessment was completed following the fall incident.

Interview with Nurse Manager(NM) #106 confirmed that there was no post fall assessment completed following the fall using the home's clinically appropriate fall assessment instrument.

B). Review of a video surveillance footage indicated that RN #101 forcefully pulled resident #003 causing them to fall. Further review of the progress note did not indicate if the fall incident was reported to the home management team and there was no post fall assessment completed.

Interview with the DOC confirmed that it is the expectation of the home that registered staff immediately report incidents of fall, complete post fall assessment, using the home's clinically acceptable fall assessment tool. [s. 49. (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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were always kept inaccessible to residents.

A CIS was received by the MLTC regarding resident #003. The report indicated that the resident ingested an identified liquid solution and was hospitalized the same day.

Review of the records indicated that resident #003 passed away in the hospital. The hospital contacted the Coroner's office and an autopsy test was conducted to determine the cause of death.

Review of the home's investigation notes indicated that the home reviewed a video surveillance footage and interviewed staff members. The investigation outcome indicated that PSW #102 observed the resident carrying a liquid solution container but did not witness them drinking it. The notes also indicated that the review of the video surveillance footage did not indicate if the resident ingested the liquid material. The records further indicated that the home was unable to contact the Coroner for further details regarding the autopsy results.

Interview with the Coroner indicated that they conducted a preliminary and detailed

autopsy test to determine the cause of the death. The Coroner indicated that the preliminary test did not indicate any liquid material ingestion, and the cytology and culture results were pending.

Inspector #645 conducted a tour of the home and observed the following:

- On an identified date, the inspector observed a portable utility cart parked in the hallway on the second floor. On the cart, a liquid bottle (labeled toxic if consumed) was stored. The bottle was left open, unsupervised, and accessible to residents.

- On an identified date, the clean utility room door on the fourth floor was left open and was accessible to residents on a secure home area. The room was a storage area and stored numerous bottles of hazardous chemicals and materials that are labeled very toxic.
- On another occasion, a portable utility cart was parked in the hallway on the second floor. On the cart was a liquid bottle that contained solutions (labeled toxic if consumed). The cart was unsupervised and accessible to residents.

Interview with PSW #104 indicated that they left the portable utility cart in the hallway because they had to go assist a resident and indicated that they normally store the cart in the dirty utility room. Interview with RN #107 indicated that they always supervise the hallways and remind staff members to store the carts in a secure storage area to keep it inaccessible.

Interview with the DOC indicated that the home has an auditing system in place to monitor, store and keep hazardous solutions inaccessible. Staff members are always expected to liquid soaps inaccessible, place the portable cart in the clean or dirty utility room and lock the door. [s. 91.]

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 all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: 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 were stored in an area that was secure and locked.

On an identified date, Inspector #645 observed the following medications stored on the counter top in the utility room:
- a medicated topical cream called Infazinc (Zinc oxide cream, 8%),
- Diclofenac Sodium 1.16% (Emulgel),
- Unlabelled and open Calamine topical cream,
- Clotrimazole 1% topical antibiotic and
- Unlocked wound treatment cart that contained topical creams, hydrogen peroxide, normal saline, scissors and other antiseptic solutions.
The utility room door was open, and the above-mentioned medications were accessible to residents.

RN #100 indicated during an interview that medicated/prescribed topical creams and the treatment cart should be safely stored in the secure medication room located behind the nursing station. The RN acknowledged that the utility room is not the designated medication storage area. They also indicated the door to the utility room was open, and the medications were accessible to residents.

Interview with the DOC indicated that it was the expectation of the home that medications and treatment carts were safely stored in the locked medication room. The DOC confirmed that storing medications outside of the medication room poses a risk to other residents. [s. 129. (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, (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, to be implemented voluntarily.

WN #6: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Record review of the investigation note for an identified CIS, indicated that resident #003 was experiencing enteric symptoms and upper respiratory congestion.

Review of a video surveillance footage on an identified date, indicated that resident #003 was observed not wearing their pants, soiled with body fluids and was walking in the hallway. RN #101 approached the resident and provided care without wearing gloves and gowns.

Review of the disciplinary letter, indicated that RN #101 was disciplined for not placing the resident on isolation precaution after they exhibited active evidence of enteric and respiratory symptoms.

Interview with the DOC confirmed that resident #003 was having enteric and respiratory symptoms on the identified date. The DOC indicated that it was the expectation of the home that staff place the resident on isolation precaution. In this case, RN #101 did not implement the infection prevention and control program of the home when they failed to place the resident on isolation precautions and don the appropriate Personal Protective Equipment (PPEs) on the identified date

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 all staff participate in the implementation of the home's infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's pain management program to identify and manage pain in residents was implemented in the home.

Review of the home's policy titled "Pain Assessment and Management, NRS-13-010" under the Home's pain management program directed staff members to complete a pain assessment using the "Initial Pain Assessment" tool when a resident is cognitively intact and "Pain Assessment in Advanced Dementia (PAINAD) tool when the resident is cognitively impaired. The policy indicated the following:
- complete pain assessment when the resident is a new admission,
- significant change to the resident's health condition and when pain is not relieved

following the initial pain treatment. The home's pain management strategies, under fall and fall prevention program, also directed staff members to observe and assess pain, and document pain site, quality, location and onset, when a resident has a fall.

1). A CIS was received by the MLTC regarding a fall with injury of resident#002. The report indicated that the resident sustained injury to the identified part of their body.

Record review of the Resident Assessment Protocols (RAPs), indicated that the resident had an identified type of disease that caused memory impairments. The assessment indicated that resident #002 had ongoing communication problems and responsive behaviours.

Record review of the progress note indicated that resident #002 had a fall on an identified date. The notes indicated that the resident was exhibiting responsive behaviours at the time and the resident's family member, assisted staff members to take them to their room. The notes revealed that the resident complained of pain while ambulating to their room. Review of the records did not indicate if pain assessment following the fall was completed. Record reviews indicated that the resident was observed having difficulty ambulating. The home's nurse practitioner's assessment notes on the same day, indicated that resident was agitated, unable to weight bear and showed non verbal pain facial expressions upon touch and when walking. The resident later was diagnosed with injury of the identified body part. The records indicated that pain assessment was completed after the resident was diagnosed with the injury . The records did not indicate if pain assessment was completed immediately following the fall incident and the next day when the resident was unable to weight bear and showing non-verbal markers of pain. There was no documentation available describing the type, severity, quality, location, onset, duration, and precipitating factors of the pain.

Interview with RN #100 confirmed that there was no pain assessment completed following the fall incident and the next day when the resident was unable to weight bear and showing non-verbal markers of pain.

2). Record review of the progress notes for resident, #001 indicated that they had a fall. Review of the records did not indicate if pain assessment was completed following the fall incident.

Interview with NM #106 confirmed that there was no pain assessment completed following the fall incident on the identified date. They indicated that it is the expectation of

the home that staff members complete pain assessments using the home's clinically appropriate pain assessment tool.

Interview with the DOC, who is also the pain management lead, confirmed that the staff members did not complete pain assessment following the fall incidents and when the resident was exhibiting non verbal pain markers. The DOC indicated that under the home's pain management program, registered staff are expected to complete pain assessments using the home's specified pain assessment tools when a resident exhibits pain and confirmed that the registered staff did not implement the home's pain management program. [s. 48. (1) 4.]

Issued on this 4th day of December, 2019

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

Original report signed by the inspector.