Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 18, 2020	2020_630589_0003	024128-19, 024397-19	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

JOANNE ZAHUR (589)

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): February 11 and 12, 2020.

During this inspection the following were inspected:
Log #024128-19 and log #024397-19, related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Manager (NM), Registered staff (RN/RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector observed staff to resident interactions, and the provision of care, reviewed health records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put any strategy in place, the strategy was complied with.

In accordance with O. Reg. 79/10, s.48 (1) 1 and in reference to O. Reg. s. 49 (1), the licensee was required to have a Falls Prevention and Management Program that provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy regarding Falls Prevention and Management-Nursing-NMIIF005, dated July 16, 2018. The policy indicates under post fall management, that the RN/RPN will on each shift observe the resident closely for 48 hours and document observations in the resident's electronic file.

1.A critical incident system (CIS) report was submitted to the Director for a fall incident involving resident #002. The CIS report further indicated that after an identified amount of time after the fall, they required to be transferred to hospital where they were diagnosed with an injury.

A review of resident #002's documentation notes indicated an initial falls incident entry with no injury noted. Further review of the documentation notes indicated that the next day, resident #002's family member reported an area of altered skin integrity to resident #002. The family also indicated they had reported this to the previous shift's registered staff. The documentation notes further indicated that there was no documentation of observations on four shifts during the 48-hour period after the fall incident as specified in the long-term care homes (LTCH) policy.
Observations conducted 48 hours after the fall incident by a registered staff indicated

altered skin integrity to a specified area of the body and a change in resident #002's health condition.

During a conversation, staff #105 acknowledged that the falls policy was in the process of being revised and that they had recognized this gap in the documentation by registered staff after a resident fall incident.

During an interview, staff #106 acknowledged that registered staff had not complied with the home’s policy which indicated the RN/RPN would observe resident #002 closely for 48 hours and document observations in their electronic file on each shift.

Related to non-compliance for resident #002, under falls prevention, the scope was expanded to include resident #003.

2.A review of resident #003’s documentation notes indicated a fall incident had occurred. The documentation notes further indicated that on five specific shifts there was no documentation of observations during the 48-hour period after the fall incident as specified in the long-term care homes (LTCH) policy:

During a conversation, staff #105 acknowledged that the falls policy was in the process of being revised and that they had recognized this gap in the documentation by registered staff after a resident fall incident. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

Issued on this 18th day of February, 2020

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

Original report signed by the inspector.