Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: November 5, 2024

Inspection Number: 2024-1437-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Advent Health Care Corporation

Long Term Care Home and City: Valleyview Residence, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24 to 25, 29 to 31, November 1 and 4, 2024
The inspection occurred offsite on the following date(s): October 28 and November 1, 2024

The following intake(s) were inspected:

- Intake: #00118959 / Critical Incident (CI) #2954-000022-24 was related to fall of resident resulting in injury
- Intake: #00126621 / CI #2954-000031-24 was related to outbreak of infectious disease
- Intake: #00126081 was a complaint related to multiple aspects of care

The following intakes were completed in this inspection:

- Intake: #00128645 / CI #2954-000034-24 and Intake: #00130118 / CI #2954-000036-24 were related to outbreak of infectious disease
- Intake: #00120609 / CI #2954-000023-24 and Intake: #00126303 / CI #2954-000030-24 were related to fall of resident resulting in injury

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to implement the written policies and protocols for the medication management system for a resident.

Rationale and Summary
A resident had a physician's order for a medicated cream to be applied topically.

Home's policy titled 'Medication Administration' with effective date of April 15, 2024,

directed administering nurse to immediately document all medication administered on the Medication Administration Record (MAR) / electronic MAR, and Treatment Administration Record (TAR) / electronic TAR.

Upon review of the progress notes and electronic MAR / TAR, it was noted that on two occasions, a Registered Practical Nurse (RPN) had applied the medicated cream for the resident, but administration of the treatment was not documented in electronic MAR / TAR.

The RPN and the Director of Care (DOC) confirmed that the administration of treatment was not recorded in the electronic MAR / TAR; and it should have been recorded.

Failure to document accurate administration of the medicated cream increased the risk of miscommunication about the treatment administered for resident. .

Sources: Review of resident's clinical records including progress notes, electronic MAR / TAR, policy titled 'Medication Administration' with policy #NRS-10-012, effective date April 15, 2024; and interview with RPN and DOC.