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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 16, 2013	2013_219211_0007	T-000752-12/T-2138-12/T-82-13	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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 17, 18, 22, 23, 24, 25, 26, 29, 30, 2013 and May 1, 2, 6, 8, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Senior Resident of Care Manager, Resident and Family Relation Coordinator, Registered Staff

During the course of the inspection, the inspector(s) reviewed clinical records, reviewed Pharmacy Policy and Procedure Manual for LTC Homes "Medication Incident Report" and "Medication Reconciliation".

The following Inspection Protocols were used during this inspection:
Medication

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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	Legendé 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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to report immediately to the Director a written complaint by resident #2's family.

On October 2012, Resident #2's family forward a letter to the Director of Care that they believed a medication was not administered in accordance with the direction for use specified by the prescriber.
On November 16, 2012, a written response by the Director of Care was communicated to the family regarding the results of the investigation. On May 8, 2013, the Administrator confirmed that the complaint was not forwarded to the Director. [s. 22. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was provided to a written complaint within 10 business days.

On October 31, 2012, Resident #2's family forward a letter of complaint to the Director of Care. On November 16, 2012, a response was sent to the family. [s. 101. (1) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to resident #1 in accordance with the direction for use specified by the prescriber.

A review with the clinical report confirmed that resident #1's patch medication was not changed as ordered by the physician on March 29, 2012. Resident #1's patch medication dated March 28, 2012 was found on her/his chest April 1, 2012. [s. 131. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. On April 1, 2012, the licensee didn't ensure that all appropriate actions are taken in response to the medication incident. The licensee did not ensure that the pharmacy policy and procedure manual for LTC homes "reporting and communications" put in place has been complied with.

On April 1, 2012, resident #1's family and a staff reported that a medication patch dated March 28, 2012 was still on resident #1's chest. Review specified that the medication was prescribed March 29, 2012 and discontinued on March 30, 2012. Then, the medication was prescribed again on April 1, 2012. The Director of Care and the manager confirmed that the procedure to report a medication incident was not followed and directed in the pharmacy policy and procedure manual for LTC homes "reporting and communications" [s. 135. (1)]

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Issued on this 16th day of May, 2013

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