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 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, 2013	2013_159178_0007	T-2-13/T-59-13	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

SUSAN LUI (178)

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): May 6, 7, 8, 9, 10, 13, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care, Resident and Family Relations Coordinator, Senior Nurse Manager, Physiotherapist, RAI-MDS and Rehabilitation Coordinator, registered staff, personal support workers (PSWs), residents, family members of residents,

During the course of the inspection, the inspector(s) observed resident care, reviewed resident and home records.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. Staff interviews and record review confirm that after Resident #2 fell during the night of January 3, 2013, staff did not collaborate with each other in their assessment of the resident.
Resident # 2 was found on the floor beside his/her bed at approximately 0300h on an identified date. The resident's vital signs were checked by the night registered staff and the resident was returned to bed. The resident was assessed by the physician at 0710h and by the day registered staff at approximately 0720h. The resident was found to have pain with movement of left hip, bruising to left wrist, and had vomited brown emesis. The personal support worker (PSW) providing care to the resident that day was aware only that the resident had vomited and would be transferred to hospital. The fact that the resident had fallen during the night was not communicated to the PSW. As a result, the PSW changed Resident# 2's shirt in preparation for his/her transfer to hospital, unaware that the resident may have sustained injuries from a fall during the night. [s. 6. (4) (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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. Staff interviews and a review of staffing schedules confirmed that between December 1, 2012 and January 8, 2013, the home did not have at least one registered nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times. This includes the night of Jan 2, 2013 when Resident #2 fell and fractured his hip and wrist, but was not sent to hospital until 4 hrs later when the day staff arrived. Home records confirm that during 12 night shifts and one evening shift between December 1, 2012 and January 8, 2013, the licensee failed to ensure that at least one RN who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home. During these 13 shifts the home's staff included an RN from an Agency. Staff interviews confirmed that on each of these shifts an RN who is both an employee of the licensee and a member of the regular nursing staff of the home had originally been scheduled, however due to illness, bereavement or family emergencies, the home's RN had been unable to fulfill the shift. The home did attempt to fill the shifts with an RN who is an employee of the home, but was unsuccessful. [s. 8. (3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #2's plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.
Staff interviews and record review confirm that after Resident #2 fell on an identified date, the resident's plan of care was not based on an interdisciplinary assessment with respect to the resident's health conditions including pain, risk of falls and other special needs.
The resident was found on the floor beside his/her bed at approximately 0300h. The registered nurse (RN) on duty, who was from an Agency, assessed the resident's vital signs and assisted the PSW (personal support worker) to return the resident to bed. The resident's pain was not assessed or treated. Despite the resident calling out in pain and asking to see a doctor, a physician was not notified of the incident until 0700h. The resident was then assessed by the physician and the day registered staff, and was transferred to hospital where he/she was diagnosed with a fractured left hip and a fractured left wrist. [s. 26. (3) 10.]

2. The licensee failed to ensure that the plan of care for Resident # 1 was based on an interdisciplinary assessment of the resident's safety risks.

Record review and staff interviews confirm the following:
In August 2012 Resident #1 was assessed to be at risk for entrapment with the use of side rails while in bed. As a result, the resident's side rails were removed and replaced with assist bars on each side. Progress notes and staff interviews confirm repeated incidents of the resident moving all over the bed, positioning his/herself close to the edge of the bed, pushing against side rails and attempting to climb out of bed before the side rails were removed. Progress notes and staff interviews confirm that after the side rails were removed the resident continued to move restlessly in bed, frequently positioning his/herself at the edge of the bed and attempted to climb out of bed on several occasions. Direct care staff expressed concern for the resident's safety, noting on November 22, 2012 that "bed was noted on such a high level that safety from a fall incident is a concern for the resident. PSW claimed it had been reported for a week now and no action as of yet".

The resident's plan of care addressed the resident's risk of entrapment, but did not address the direct care staff's assessment that the resident was at risk for injury from falling out of bed after the side rails were removed. When the resident's side rails were removed no precautions were taken to minimize the chance of injury in case the

resident was to climb or fall out of bed.
Staff interviews confirm that no interventions were put in place, including but not limited to, a Hi-Low bed, crash mats on the floor, or a bed alarm. On December 21, 2012, the resident fell from bed and sustained a laceration above the right eye requiring transfer to hospital for sutures.
After the resident fell on December 21, 2012, a Hi-Low bed was provided, crash mats were placed on either side of the resident's bed when he/she was in bed, and a bed alarm was provided. [s. 26. (3) 19.]

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 plan of care for each resident is based on, at a minimum, interdisciplinary assessment of safety risks and pain, to be implemented voluntarily.

WN #4: 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 resident is assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
Staff interviews and record review confirm that after Resident #1 fell on an identified date, a post fall assessment was not conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

2. Staff interviews and record review confirm that after Resident #2 fell on an identified date, a post fall assessment was not conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [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, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Staff interviews and record review confirm that Resident #1 was found on the floor beside his/her bed at 0400h on Dec 21, 2012 and was sent to hospital for assessment and treatment. The home did not report the fall with injury to the Ministry of Health and Long-Term Care (MOHLTC) within one business day after the incident. The home reported the incident in a CIS report submitted on Dec 31/12 at 2106h. [s. 107. (3) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 207. Transfer list
Specifically failed to comply with the following:

s. 207. (5) In filling vacancies for basic accommodation, the licensee shall alternate on a bed-by-bed basis between,
(a) residents who are requesting a transfer from preferred accommodation in the home to basic accommodation; and O. Reg. 79/10, s. 207 (5).
(b) admissions authorized by the appropriate placement co-ordinator. O. Reg. 79/10, s. 207 (5).

Findings/Faits saillants :

1. The licensee has failed while filling vacancies for basic accommodation, to alternate on a bed-by-bed basis between (a) residents who are requesting a transfer from preferred accommodation in the home to basic accommodation; and (b) admissions authorized by the appropriate placement coordinator.
Resident # 1 has been on the home's Transfer List for residents requesting transfer from preferred accommodation to basic accommodation since October 2009.
Staff interviews and record review confirm that a basic accommodation bed which should have been offered to Resident # 1 in January 2013 was erroneously offered to an admission from the community instead. [s. 207. (5)]

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Issued on this 29th day of May, 2013

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

Susan Lee (175)