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

Division de la responsabilisation et de la performance du système de santé
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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
Jul 22, 2014	2014_159178_0014	T-699-13	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

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

This inspection was conducted on the following date(s): June 3, 5, 10, July 18, 2014

During the course of the inspection, the inspector(s) spoke with Director of Care, nurse manager, registered staff, family of a resident.

During the course of the inspection, the inspector(s) reviewed resident records.

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

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.) 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Staff interview and record review confirm that the results of the head injury routine conducted after resident # 1 fell and hit his/her head on an identified date, were not documented.
The registered staff member on duty at the time of the resident's fall stated that head injury routine was initiated after resident # 1 fell, and that a head injury assessment was conducted three times. However, the resident's record does not contain the results of these assessments, apart from one incident note which states that the resident was alert and responding to verbal and painful stimuli after the fall. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report was made in writing to the Director under the LTCHA of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Record review and staff interviews confirm that resident # 1 fell in the home on the morning of an identified date. The resident was transferred to a clinic for assessment that afternoon, and shortly thereafter was transferred from the clinic to hospital and diagnosed with a fractured left hip. The resident subsequently died in hospital approximately one week later.
Record review and staff interviews confirm that the Director under the LTCHA was never notified of the incident or of the resident's subsequent death. [s. 107. (4) 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 ensure that a report is made in writing to the Director under the LTCHA of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 138. Absences Specifically failed to comply with the following:

s. 138. (7) A licensee of a long-term care home shall ensure that when a resident of the home leaves for a medical absence or a psychiatric absence, information about the resident's drug regime, known allergies, diagnosis and care requirements is provided to the resident's health care provider during the absence. O. Reg. 79/10, s. 138 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident of the home leaves for a medical absence, information about the resident's drug regime, known allergies, diagnosis and care requirements is provided to the resident's health care provider during the absence.

Family interview, staff interview and record review confirm that when resident # 1 fell and was transferred to a clinic for assessment, information regarding the resident's drug regime, diagnosis and care requirements was not provided to the clinic staff.
Resident # 1 fell on the morning of an identified date, and was transferred to a clinic for assessment that afternoon.
Staff interviews confirm that the resident's medication administration record (MAR) and most recent labwork should have been sent with the resident, but were not.
Staff interview confirms that a transfer paper was sent with the resident, which included an assessment of the resident after the fall, but no MAR or history or labwork results were sent with the resident when he/she was sent to a clinic for assessment after his fall. [s. 138. (7)]

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 of the home leaves for a medical absence, information about the resident's drug regime, known allergies, diagnosis and care requirements is provided to the resident's health care provider during the absence, to be implemented voluntarily.

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Issued on this 22nd day of July, 2014

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

Anson Sin (178)