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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 18, 2014	2014_261522_0035	L-001583-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF ST. THOMAS
545 TALBOT STREET P. O. BOX 520 ST. THOMAS ON N5P 3V7

Long-Term Care Home/Foyer de soins de longue durée

VALLEYVIEW HOME
350 Burwell Road ST. THOMAS ON N5P 0A3

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

JULIE LAMPMAN (522), INA REYNOLDS (524), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 2, 3, 4, 5, 8, 9, 10 and 11, 2014.

A concurrent Complaint Inspection 004903-14 was conducted during the RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Activation Supervisor, Volunteer Coordinator, CQI Coordinator, RAI Coordinator, four Registered Nurses, seven Registered Practical Nurses, nine Personal Support Workers, two Maintenance Staff, two Housekeeping Staff, a Dietary Aide, an Activity Aide, a Hairdresser, four Family Members and forty Residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **8 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Record review of the most recent plan of care on Point Click Care revealed Resident #34 requires two full padded bedrails elevated when in bed for safety and that the resident is at high risk for falls. Resident room observation on December 4, 2014 revealed two stars were placed above the bed on the wall to alert staff that the resident is at high risk.

Record review of the hard copy of the "CCRS MDS Kardex Report for Valleyview" revealed the resident requires "1 half rail elevated while in bed." One star was placed on the Kardex to alert staff that the resident is at low or medium risk for falls.

Interview with the Registered Practical Nurse confirmed Resident #34 does require two full padded bedrails for safety and is at high risk for falls.

Interview with the RAI Coordinator confirmed that the written plan of care and Kardex were not consistent and did not set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan is no longer necessary.

On December 4, 2014 a review of Resident #41's plan of care revealed interventions for altered skin integrity.

Review of the resident's progress notes on a specified date revealed the resident no longer had altered skin integrity.

Interviews with the Registered Practical Nurse (RPN) and Personal Support Worker revealed the resident no longer had altered skin integrity.

The RPN confirmed the resident's plan of care had not been updated to reflect the resident no longer had altered skin integrity.

Interview with the Director of Care confirmed the expectation that the plan of care be reviewed and revised when the care set out in the plan is no longer necessary. [s. 6. (10) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Review of the MDS annual assessment and MDS quarterly review assessments revealed Resident #1 had a significant change in bladder continence. No continence assessment was found in the plan of care.

Interview with a Registered Staff member revealed there is no documented evidence of a completed clinically appropriate assessment tool for incontinence in the electronic or hard copy files. [s. 51. (2) (a)]

2. Review of Resident #43’s MDS Assessment revealed the resident is now totally incontinent of bladder and usually continent of bowel.

Review of the resident’s clinical record revealed the absence of a documented continence assessment. This was confirmed by the Registered Nurse.

Review of the home's Continence Care and Bowel Management Program Policy No. RC&S 07-10 revealed "a comprehensive bladder and bowel continence assessment will be completed by the RN/RPN for all residents on admission, with any significant change RAI-MDS 2.0 Assessment and whenever there is a change in the resident’s status that affects continence."

Interview with the Director of Care confirmed the expectation that the resident receive a continence assessment with any significant change in continence. [s. 51. (2) (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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure a written response is given within 10 days of receiving Residents' Council's concerns or recommendations.

Review of the home's Residents' Council Concern Form on December 9, 2014 at 1000 hours revealed the following: "This form must be submitted to the appropriate Department Head/Administrator within 7 days of the Residents' Council Meeting date. The Administrator is responsible to approve the response to Councils' concerns or recommendations within 21 days of the meeting."

Review of the Residents' Council Meeting Minutes for October 2014, revealed the Council brought forth a concern and a response was provided by the Activation Director at the meeting. Despite concerns being identified in writing, there was no documentation to support that a written response was provided to Council using the home's Resident Council Concern Form.

Interview with the President of the Residents' Council on December 9, 2014 at 0910 hours revealed no recollection of a written response from the Administrator regarding any past concerns; any concerns are shared directly with the Administrator by the Resident Council President.

Interview with the Activation Supervisor on December 9, 2014 at 0945 hours revealed they were unaware that the home was required to respond, in writing, within 10 days of concerns or recommendations being made.

Interview with the Administrator on December 9, 2014 at 1015 hours confirmed that the home was unaware that the home was required to respond, in writing, within 10 days of concerns or recommendations being made. Moving forward the form is being revised and the response in writing within 10 days of receiving the concern or recommendation initiated. [s. 57. (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 a written response is given within 10 days of receiving Residents' Council's concerns or recommendations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance required by the resident.

Observation of the lunch meal service in a specified dining room on December 2, 2014 revealed the soup for four residents was set on their tables uncovered at approximately 1200 hours by the Dietary Aide; however no one was available to assist these residents until 1204 1207, 1212 and 1214 hours respectively.

Observation of the lunch meal service in the same dining room on December 5, 2014 revealed the soup for a resident was set out uncovered at 1152 hours by a Personal Support Worker; however no one was available to assist the resident until 1202 hours. One staff member was observed assisting two residents with eating and drinking and then moved and turned around to feed a third resident at the table for approximately 5 minutes. These residents entrées then sat uncovered for the duration until assistance was provided once again.

The Director of Care confirmed the expectation that meals are only served when someone is available to provide assistance. [s. 73. (2) (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 residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Review of the Residents' Council meeting minutes for September, November and December 2014 revealed the absence of documentation regarding the discussion with Residents' Council in developing and carrying out the 2014 resident satisfaction survey.

Interview with the Residents' Council president on December 9, 2014 at 0910 hours revealed that Council has not been asked to advise the home in the development of the Resident Satisfaction Survey.

Interview with the Activation Supervisor on December 9, 2014 at 0945 hours confirmed that the home did not seek the advice of Residents' Council in the development of the Resident Satisfaction Survey which was carried out in November 2014.

Interview with the Administrator confirmed the expectation that the home seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the satisfaction survey are made available to the Residents' Council in order to seek advice of the Council about the survey.

Interview with the Residents' Council president on December 9, 2014 at 0910 hours revealed the president was unable to confirm that previous satisfaction survey results were shared with Residents' Council.

Interview with the Activation Supervisor on December 9, 2014 at 0945 hours revealed that the results of the satisfaction survey have not been shared with the Residents' Council.

Interview with the Administrator on December 9, 2014 at 1015 hours confirmed the expectation that satisfaction survey results are made available to the Residents' Council in order to seek the advice of the Council about the survey. [s. 85. (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 the licensee seeks the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results and that the results of the satisfaction survey are made available to the Residents' Council in order to seek advice of the Council about the survey, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

Review of twelve resident clinical records on December 8, 2014 at 1145 hours revealed these residents have all available medical directives ordered by the physician and available for use including Glucagon Injection and Nitroglycerine Spray. These residents do not have a diagnoses of Angina or Diabetes.

Interview with the Director of Nursing confirmed the expectation that medical directives should be ordered and used according to each resident's individual condition and needs. [s. 117. (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 no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #7: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Resident interview and observations on December 3 and 4, 2014 revealed Resident #35 kept a medication on the counter in a shared bathroom for self-administration.

Interview with the Assistant Director of Care on December 3, 2014 confirmed the medication should not be kept in the resident's shared bathroom.

Interview with the Registered Nurse and record review of physician's orders revealed the absence of a physician's order for Resident #35 to self-administer the medication or for the medication to be kept in a shared bathroom.

Review of the Self-Administration of Medication policy No. 4.17 dated September 1, 2013 revealed the following: "The resident's Physician must authorize the resident to have possession of the drug" and "The safe and proper storage of the medication must be assured to restrict access to anyone other than the resident."

Interview with the Director of Care on December 5, 2014 confirmed the expectation that no resident self-administers a drug unless approved by the prescriber and that the policy for self-administration should be followed. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observations of ten shared bathrooms revealed numerous used and unlabeled personal care items.

Interview with a Personal Support Worker confirmed the items were not labeled and that all personal care items should be labeled.

Interview with the Director of Care revealed the home's expectation is that all resident personal hygiene items are labeled and stored in residents' individual baskets. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a restraint is included in the resident's plan of care.

Observations of Resident #42 on December 8 and 9, 2014 revealed the resident was using a specified restraint.

Interview with the Personal Support Worker and the Registered Nurse confirmed the resident uses the restraint when the resident is in the chair.

Review of the resident's plan of care revealed the absence of documentation related to the use of the restraint. There were no physician's order or consent for the use of the restraint.

Interview with the Director of Care confirmed the expectation that the use of the restraint be included in the resident's plan of care. [s. 31. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

Observations of Resident #42 on December 8 and 9, 2014 revealed the resident was using a specified PASD.

Interview with the Personal Support Worker and the Registered Nurse confirmed the resident uses the PASD when in the chair.

Review of the resident's clinical record revealed the absence of documentation related to the use of the PASD.

Interview with the Director of Care confirmed the expectation that an assessment of the resident is completed prior to the use of a PASD and that the plan of care be updated to include the use of the PASD. [s. 33. (3)]

Issued on this 18th day of December, 2014

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

Original report signed by the inspector.