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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 19, 2016	2016_263524_0014	034643-15	Critical Incident System

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

INA REYNOLDS (524), CAROLEE MILLINER (144), CHARLES SMITH (635), CHRISTINE MCCARTHY (588), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 4, 5, 6, 7, 8, 11, 12, 13, 2016.

The following Critical Incident inspections were conducted concurrently with this inspection:
CI 2954-000032-14 / Log # 003211-14 related to allegations of resident to resident abuse

CI 2954-000048-14 / Log # 005932-14 related to allegations of resident to resident abuse
CI 2954-000047-14 / Log # 006256-14 related to allegations of staff to resident abuse
CI 2954-000050-14 / Log # 007741-14 related to allegations of resident to resident abuse
CI 2954-000054-14 / Log # 009651-14 related to allegations of resident to resident abuse
CI 2954-000055-14 / Log # 010212-14 related to allegations of resident to resident
CI 2954-000007-14 / Log # 030927-15 related to resident attempt to self-harm
CI 2954-000019-14 / Log # 030929-15 related to transferring and positioning techniques
CI 2954-000003-15 / Log # 000949-15 related to allegations of staff to resident abuse
CI 2954-000005-15 / Log # 004895-15 related to allegations of staff to resident abuse
CI 2954-000008-15 / Log # 007535-15 related to allegations of resident to resident abuse
CI 2954-000009-15 / Log # 009906-15 related to allegations of staff to resident abuse
CI 2954-000010-15 / Log # 012399-15 related to allegations of resident to resident abuse
CI 2594-000016-15 / Log # 034643-15 related to transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Nurse Manager, two Nurse Managers, the Quality Improvement Coordinator, the Office Manager, the Resident and Family Relation Coordinator, the Clinical Nurse Manager Assistant, three Registered Nurses, seven Registered Practical Nurses, ten Personal Support Workers, one Activity Assistant, two Physiotherapist Assistants and 15 residents.

The inspector(s) also observed resident and staff interactions, care and activities provided to residents, infection prevention and control practices, reviewed residents' clinical records, critical incidents, internal investigation notes, staff education records and reviewed relevant policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
3 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).

Findings/Faits saillants :

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

Record review of an Amended Critical Incident report revealed under the Analysis and Follow-up section that, "resident is now a 2 person assist for care."

Record review of the care plan for the identified resident revealed "one person assist" with all care. Record review of Point of Care, Kardex revealed an absence of any specified number of staff to assist with care. Record review of the Annual Summary Conference revealed an absence of any specified number of staff to assist with care. Record review of the Minimum Data Set Assessment revealed an absence of any specified number of staff to assist with care.

Interview with a Personal Support Worker revealed this resident was very resistive to care and they would re-approach the resident. The Personal Support Worker revealed that they provided care to the resident by themselves. Interview with another Personal Support Worker revealed that the only time two staff provided care for the identified resident was on shower days and when the resident was agitated.

Interview with the Clinical Nurse Manager confirmed the absence of "2 person assist for care" in the plan of care and that the expectation was that the plan of care provided clear direction to staff and others who provided direct care to the resident. [s. 6. (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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home’s written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's Zero Tolerance for Abuse and Neglect policy number ADMVIII005vv effective January 2016, included the following directive under Reporting Resident Abuse or Neglect: "Upon verification, Administrator or designate will call Toronto Police Communication Department Radio Room to report alleged abuse."

A) A Critical Incident report was submitted to the Ministry of Health and Long Term Care Critical Incident Report System related to allegations of staff abuse toward an identified resident.

Review of the Critical Incident report revealed the home's Zero Tolerance for Abuse and Neglect policy was not followed in that the Toronto Police Communication Department Radio Room was not contacted.

The Director of Care confirmed with the Inspector that the home's Zero Tolerance for Abuse and Neglect Policy was not followed and that the Toronto Police Communication Department Radio Room was not notified of the allegation of staff to resident abuse toward the resident.

B) Two Critical Incidents related to a resident to resident incident resulting in injury was submitted to the Ministry of Health and Long Term Care Critical Incident Report System on two different dates.

Interviews with the Administrator and the Director of Care revealed that the home does not notify police if the incident involves two cognitively impaired residents. The Director of Care confirmed that the home did not call the police after these separate incidents, and did not follow the home’s policy and procedure related to reporting abuse.

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 home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) Record review revealed that an identified resident sustained an injury during a transfer from bed to wheelchair. Record review of the plan of care under the transferring section revealed the resident was to be transferred safely with the assistance of a transferring device.

Record review of the home's investigation notes revealed that a Registered Practical Nurse and a Personal Support Worker transferred the resident without the assistance of a transferring device from bed to wheelchair. The Registered Practical Nurse was aware that the resident was assessed for a transferring device.

Interview with the Director of Care on April 5, 2016, confirmed that staff should have used a device when transferring the resident and had not used a safe transferring technique when assisting the resident, resulting in an injury.

B) Record review revealed that an identified resident sustained an injury during a transfer from wheelchair to bed. Record review of the plan of care under the transferring section revealed the resident was to be transferred safely using a transferring device with two persons assistance.

Record review of the home's investigation notes revealed that a Personal Support Worker did not follow the plan of care and acknowledged transferring the resident without the assistance of a co-worker.

Review of the home's "Staff Zero Lifting and Transferring Guidelines" policy number HSXVIII040 dated January 2016, revealed that "two staff must be present for the entire mechanical lifting procedure" to provide a safe environment for all residents.

Interview with the Nurse Manager confirmed that the Personal Support Worker transferred the resident from wheelchair to bed alone and had not used a safe transferring device, resulting in an injury. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions:
i. the immediate actions that had been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

Record review of an amended Critical Incident report revealed that the Critical Incident occurred on a specified date and was submitted to the Ministry of Health and Long Term Care Critical Incident Report System.

The amended version dated under section IV Analysis and follow-up revealed "Investigation in progress" and under General Notes: "Please amend the CI to include the outcome of your investigation and actions planned to prevent recurrence. Please also indicate if/when police were notified. Please also include when the PSW reported the incident to management."

Record review of the home's Zero Tolerance for Abuse and Neglect policy number ADMVIII005vv effective January 2016, revealed the following: "Advise the Ministry that the investigation has been completed and complete a final report and send to the Ministry of Health and Long-Term Care Residential Services Branch Regional Office (within 30 days of initial report to the Ministry)."

Interview with the Nurse Manager confirmed the amended Critical Incident report had not included the completion of Section IV: Analysis and Follow-up as requested by the Centralized Intake and Assessment Triage Team and that it was the expectation that the home should have done so. [s. 104. (1) 4.]

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

Issued on this 20th day of April, 2016

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

Original report signed by the inspector.