Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 12, 13, 14, 15, 18.& May 12, 13, 2011	2011_116_2954_12Apr140133	Complaint Log#T884-11

Licensee/Titulaire
Advent Care Corporation
541 Finch Avenue West, Toronto ON, M2R 3Y3

Long-Term Care Home/Foyer de soins de longue durée
Valleyview Residence, 541 Finch Avenue West

Name of Inspector/Nom de l'inspecteur
Saran Daniel-Dodd, Inspector 116

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection regarding an injury causing bodily harm. During the course of the inspection, the inspector spoke with:

- The Administrator
- Director of Care
- Life Labs Manager
- Mobile Lab Technician
- Substitute Decision Maker for resident
- Private caregiver for resident
- Registered and direct care staff members.

During the course of the inspection, the inspector: Reviewed the health record of a resident, , reviewed the complaint tracking log, reviewed Policies: Zero Tolerance for Abuse and Neglect, Complaints

The following Inspection Protocols were used in part or in whole during this inspection: Prevention of Abuse and Neglect, Reporting and Complaints, Personal Support Services.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

8 WN
4 VPC
4 CO

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* a trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 s. 19. (1). Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings:

- The licensee failed to protect a resident from neglect.
- The licensee failed to comply with the policy entitled Zero Tolerance for Abuse and Neglect NM-II-R005) which states the home strictly adheres to and enforces zero tolerance of abuse and neglect of residents.
- Resident was transferred to hospital due to an incident of alleged neglect involving the resident that resulted in injury.

Inspector ID #:	116

CO #001 - will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 s. 6 (7). The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings:

- There was no written plan of care to reflect the verbal agreement made between substitute decision maker (SDM) and Director of Care (DOC) addressing the resident's need for assistance with treatments.
- Assistance was not provided for the resident with a scheduled treatment.
- Clear direction was not provided to service provider in regards to the care requirements for the resident.

Inspector ID #:	116

CO #002 - will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with O.Reg. 79/10. s. 26 (3) (18). A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: (18) Special treatments and interventions.

Findings:

- Verbal agreement made through the SDM and Director of Care involved developing plan of care which addressed the resident's need for assistance.
- Not all personal support workers interviewed were aware of the requirement for assistance for the resident.
- Interventions for assistance were not identified in the plan of care.

Inspector ID #:	116

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to each resident :special treatments and interventions.

WN #4: The Licensee has failed to comply with O.Reg 79/10. s. 97 (1) (a), (b). Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

Findings:

- The licensee did not immediately notify substitute decision maker of an incident of alleged neglect involving the resident that resulted in injury to the resident.
- The resident's injury was reported to different members of the Registered and direct care staff.

Inspector ID #:	116

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 substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10. s. 101 (2) (a)-(f). The licensee shall ensure that a documented record is kept in the home that includes,
a)the nature of each verbal or written complaint;
b)the date the complaint was received;
c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
d)the final resolution, if any;
e) every date on which any response was provided to the complainant and a description of the response; and
f) any response made in turn by the complainant.

Findings:

- The licensee failed to ensure that verbal complaints made related to care of the resident were documented. The home does not have a documented record indicating the nature of the complaints, the date received, action taken to resolve the complaints, final resolution of the complaints, and any response to the complainant.
- Complaint tracking log does not identify verbal complaints received by The Administrator and Director of Care related to injuries sustained by the resident.

Inspector ID #:	116

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 documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10. s.101 (1), (3). 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. 3) A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Findings:

- The licensee did not investigate verbal complaints made by resident's substitute decision maker in regards to sustained injuries.
- The licensee did not provide a follow up response to substitute decision-maker of resident in regards to an incident causing injury. The resident's injury was reported to different members of the Registered and direct care staff
- Licensee failed to provide complainant with steps taken to resolve complaints.

Inspector ID #:	116

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #7: The Licensee has failed to comply with O.Reg. 79/10 s. 130 (1), (2). Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following: (1) All areas where drugs are stored shall be kept locked at all times, when not in use, (2) Access to these areas shall be restricted to, i) persons who may dispense, prescribe or administer drugs in the home, and ii) the Administrator.

Findings:

- Observation of an opened, unlocked and unsupervised medication cart was made by an inspector.
- The incident was immediately brought to the attention of staff members
- Concerns immediately brought forward to the Administrator and charge nurse. Action to prevent recurrence was taken by the Administrator.

Inspector ID #:	116

CO # 004- Will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #8: The licensee has failed to comply with LTCHA, 2007 S.O. 2007 s. 24 (1). A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Findings:

- The licensee did not immediately report an incident of improper or incompetent treatment to the Director.

Inspector ID #:	116

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 person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that results in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Jul 5, 2011