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 prévue 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 soins 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 28, 2019	2019_767643_0009	020020-18, 002235-19, 003068-19	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

ADAM DICKEY (643)

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): March 4-8, 11 and 15, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Intake Log #020020-18; CIS #2954-000015-18 - related to injury with cause unknown,
Intake Log #002235-19; CIS #2954-000001-19 - related to falls prevention and management, and
Intake Log #003068-19; CIS #2954-000004-19 - related to safe transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), Clinical Services Manager (CSM), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, review of the home's video surveillance, record review of health records and relevant policies and procedures.

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

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	Légende 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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan as required by the Regulation O. Reg. 79/10, s. 24 (1) included with respect to the resident any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

A Critical incident system (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to a fall incident on an identified date involving resident #051 which resulted in a significant change in the resident condition. The CIS showed that resident #051 had fallen in a specified resident home area and was sent to hospital for assessment. Resident #051 was admitted to hospital and diagnosed with an identified injury and received treatment.

Review of resident #051's health records showed they were admitted to the home three days prior to the fall incident. Upon admission resident #051 used a specified aide for ambulation. Review of resident #051's 24-hour care plan from the date of admission did not identify the resident's risk for falls or interventions to mitigate those risks. Review of Resident Assessment Instrument (RAI) assessment form from three weeks prior to admission, showed resident #051 had fallen in the past 30 days, as well as in the past 31 to 180 days. The assessment showed that resident #051 had become more frail but continued to use the ambulation aide, and had a specified fall prevention and management intervention in place prior to admission to the home.

In an interview, RPN #106 indicated that the process in the home when a resident was admitted was for the admitting nurse to receive the admission package and review documentation to initiate the 24-hour care plan on the document titled "initial care plan". RPN #106 indicated they would review the assessment documentation received from the placement coordinator prior to admission and conduct a falls risk assessment to determine falls risk for the resident. RPN #106 reviewed the 24-hour care plan document for resident #051 and indicated that they had a fall in the two months prior to admission, but did not identify risk for falls or interventions.

In an interview, CSM #102 indicated that the process in the home when a resident was admitted was for the admitting nurse to complete a falls risk assessment in the electronic documentation system and document the score on the 24-hour care plan document. CSM #102 indicated that resident #051 did not have a falls risk assessment conducted as per the home's policy, and that the risk for falls was not identified nor interventions to

mitigate the risk as part of their 24-hour care plan. CSM #102 acknowledged that the 24-hour care plan for resident #051 did not include risk for falling and interventions to mitigate the risk. [s. 24. (2) 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 with ensuring the required 24-hour admission care plan under O. Reg. 79/10, s. 24 (1) includes, at a minimum, with respect to the resident any risks the resident may pose to themselves, including risk of falling, and interventions to mitigate those risks, to be implemented voluntarily.

WN #2: 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 techniques when assisting residents.

A CIS report was submitted to the MOHLTC on an identified date, related to resident #061 being found to have suffered a specified injury six days earlier. Staff and resident could not identify the cause of the injury at the time the injury was discovered. According to the CIS report an investigation was carried out with review of video surveillance which concluded a PSW assisted resident #061 with transferring without the assistance of a second PSW.

Review of resident #061's plan of care showed they were to be assisted with transferring using specified transfer equipment with two staff member assistance. Progress notes by the Physiotherapist showed the resident was assessed to require the above mentioned transfer equipment lift with two staff assistance, as they were no longer able to weight bear.

Progress note from the date of the above mentioned injury, showed RPN #123 was called by a PSW at an identified time to see resident #061 finding a specified injury. Resident #061 was sent to hospital for treatment and returned to the home following a specified procedure to treat the injury.

In interviews RPN #123 and PSW #124 indicated they were working on the above identified date and had not noted anything unusual about resident #061 throughout the shift. PSW #124 indicated they were assisting resident #061 with Activities of Daily Living (ADL) when they discovered the identified injury. RPN #123 indicated that upon observation they did not note any indication the resident had sustained an injury, and that the injury did not appear to have happened at the time discovered based on its appearance.

Resident #061 was interviewed, and was able to recall that they had sustained the above mentioned injury, however they were not aware of how or when the injury might have happened. Resident #061 indicated that two staff members assist them with transferring using the above mentioned transfer equipment.

Video surveillance of the resident home area in which resident #061 resided was obtained and reviewed by the inspector. Review of the footage showed the following PSW #112 had entered the resident room with the resident on a specified piece of personal care equipment without another staff member. PSW #113 additionally entered the room for approximately 45 seconds while PSW #112 was present. Approximately 10 minutes later PSW #112 exited resident #061's resident room alone with the above mentioned specified personal care equipment, indicating PSW #112 assisted resident #061 with transfer without the assistance of another staff member.

In an interview, PSW #112 indicated that resident #061 was transferred using the above mentioned transfer equipment with assistance from two staff members. PSW #112 indicated that on the above mentioned date they had assisted resident #061 with a specified ADL and brought the resident back to their room. PSW #112 indicated that they had received help transferring resident #061 from PSW #113. PSW #112 indicated that they did not observe any injury sustained by resident #061 prior to ending their shift that day.

In an interview, PSW #113 denied assisting PSW #112 with transferring resident #061 on the above mentioned date and time. PSW #113 indicated that they were aware resident #061 required the use of the above mentioned specified transfer equipment with two staff

for assistance transferring, and had assisted in transferring the resident in the past. PSW #113 indicated they had not observed any injury to resident #061 prior to the end of their shift.

In an interview, the DRC indicated that they had reviewed the video surveillance and concluded that resident #061 had been transferred from the above mentioned specified personal care equipment by PSW #112 without the assistance of another staff member. The DRC indicated that this was against the policy of the home which states two staff members should always be present throughout a transfer using the specified transfer equipment. The DRC acknowledged that resident #061 had been transferred by one staff member on the above identified date and that safe transferring techniques were not used to assist the resident in this case. [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 #3: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that subject to subsection (3.1) the Director was informed no later than one business day of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A CIS report was submitted to the MOHLTC on an identified date related to a fall incident which occurred 31 days prior, involving resident #051 which resulted in a significant change in the resident condition. The CIS indicated that the report was submitted by Nurse Manager #111. Nurse Manager #101 was not available for interview at the time of inspection.

In an interview, DRC #101 indicated that the expectation of the home for reporting a resident with a significant change in status would be within one business day per legislation. DRC #101 indicated they had become aware of resident #051's transfer to hospital and was awaiting the hospital report to see if the fall caused a significant change in status. Inspector asked the DRC if the fall had caused a significant change in status for resident #051 and DRC #101 indicated that it had. The DRC acknowledged that a CIS was submitted to the MOHLTC 31 days following the above incident and had not been submitted within one business day as per legislation. [s. 107. (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 with ensuring that subject to subsection (3.1) the Director is informed no later than one business day 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 #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 was assessed and where the condition or circumstances of the resident required, a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls.

A CIS report was submitted to the MOHLTC related to an incident involving resident #051 which resulted in a significant change in the resident condition. The CIS showed that resident #051 had fallen in a specified resident home area and was sent to hospital for assessment. Resident #051 was admitted to hospital with an identified injury which required treatment.

Review of resident #051's progress notes showed that on an identified date, resident #051 was found on the floor in a specified resident home area by RPN #107. Resident #051 was assessed by RPN #107 and RN #105 and complained of pain and was transferred to hospital.

In interviews, RPNs #106 and #107 indicated that the assessment tool used for post fall assessment was the falls risk assessment found in the home's electronic record system. The RPNs indicated that this assessment was to be completed after every resident fall.

Review of resident #051's assessments in the home's electronic documentation system did not show completion of a falls risk assessment related to the above mentioned fall incident on the above identified date.

In an interview, CSM #102, who was the lead for the falls prevention and management program indicated that the home used the falls risk assessment as the post fall assessment tool. CSM #102 indicated that the falls risk assessment would be carried out by registered staff after every resident fall. CSM #102 acknowledged that a falls risk assessment had not been completed post fall for resident #051's fall incident on the above identified date. [s. 49. (2)]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.