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

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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_0010	030646-18	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

ADAM DICKEY (643)

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): March 13, 14, 15, 19, 20 and 21, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), former Resident and Family Relations Coordinator (RFRC), personal support workers (PSW), Pharmacy provider CEO, Pharmacy provider representative, residents, and family members.

During the course of the inspection the inspector observed staff and resident interactions and the provision of care, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Reporting and Complaints
Responsive Behaviours

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

Specifically failed to comply with the following:

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 the resident was reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) concerning the medication administration practices for resident #065. Review of MOHLTC INFOLINE complaint from an identified date, showed that resident #065's family member had concerns that the resident was not receiving care due to behaviours.

In an interview, resident #065's family member indicated that they were aware that the resident engaged in behaviours that affected care. Resident #065's family member indicated they were concerned that the staff of the home were indicating they had attempted several times, but were not doing anything additional to manage the resident's behaviour. Resident #065's family member indicated they had to assist staff with a specified activity of daily living (ADL) for the resident.

Review of resident #065's Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment from an identified date showed they engaged in this behaviour four to six of the seven day observation period, which was not easily altered. The RAI-MDS assessment showed there was no change in resident #065's behavioural symptoms over the previous quarter.

Review of resident #065's progress notes showed the resident engaged in the identified behaviour since admission to the time of the inspection. Review of resident #065's plan of care showed interventions to manage the behaviour were not changed over the six months prior to inspection. The plan of care was revised with a new intervention four months prior to inspection. No further revisions of the interventions to manage the resident's behaviour were identified.

In interviews, PSWs #125, #128 and #131 indicated that resident #065 frequently engaged in the identified behaviour. The PSWs indicated that the strategy they would use to manage resident #065's behaviour was to continue to re-approach the resident and attempt to complete the care as per the resident's plan of care. The PSWs indicated the resident engaged in the behaviour with the above mentioned ADLs and may become angry when re-approached. The PSWs indicated they were not aware of any new strategies to be used with resident #065 to manage the resident's behaviour.

In interviews, RN #127, RN #133, and RPN #132 indicated that resident #065 would frequently engage in behaviour that affected care. The registered staff indicated that strategies were in place and to continue to re-approach if refused. RPN #132 indicated that there had not been any additional strategies care planned to manage resident #065's behaviour.

In an interview, the DRC indicated that it was the expectation of the home that resident care plans would be updated on a quarterly basis and also when interventions in the care plan were not effective. The DRC acknowledged that for resident #065, the care plan had not been reviewed and revised when interventions had not been effective to manage the resident's behaviour. [s. 6. (10) (c)]

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 residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) 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:
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. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(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; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident of operation of the home; a response was made to the person who made the complaint indicating, what the licensee has done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

A complaint was submitted to the MOHLTC concerning the provision of care for resident #065. Review of interview notes from Central Intake and Triage Team with resident #065's family member showed they had indicated a teleconference meeting was held with management on an identified date discussing their concerns. In an interview with the inspector, resident #065's family member indicated they did not receive a response from the home about this complaint after the discussion with management, including the Administrator.

In an interview, the Administrator indicated they recalled being involved in a teleconference with resident #065's family member, and believed a response was made to the family member regarding their concerns. The Administrator indicated that the home's former RFRC would have been the person handling the complaint from resident #065's family member and would have made the response.

In an interview, the home's former RFRC indicated they did recall discussing the concern with resident #065's family member but would not have been the person to handle the complaint as it was a nursing issue. In an interview, the DRC indicated they had not made a response to resident #065's family member. In this case the home failed to provide a response to resident #065's family member indicating what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief. [s. 101. (1) 3.]

2. The licensee has failed to ensure that for every written or verbal complaint received under O. Reg. 79/10, s. 101 (1), a documented record was kept in the home that included: the nature of each verbal or written complaint, the date the complaint was received, actions taken to resolve the complaint, final resolution, dates communicating with the complainant and any response made by the complainant.

Review of the home's complaint log did not show a record of the complaint regarding provision of care from resident #065's family member.

In an interview, the Administrator indicated they recalled being involved in a teleconference with resident #065's family member, and that the home's former RFRC would have kept a record of the complaint. The Administrator indicated that they had a conversation with the former RFRC about the complaint and indicated to the inspector that any documentation the RFRC maintained had possibly been shredded. The Administrator acknowledged that a written record was not kept in the home of the complaint regarding medication administration from resident #065's family member. [s. 101. (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 with ensuring:
- that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home a response shall be made to the person who made the complaint, indicating, what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief, and
- 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol or procedure, the licensee is required to ensure that the plan, policy, protocol or procedure was complied with.

In accordance with O.Reg.79/10, s.114 (2), the licensee was required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Review of the home's pharmacy provider's policy titled Documenting Transcription of Orders on Electronic Medication Administration Records (e-MAR) policy number 4.06 (a) revised October 18, 2015, showed that staff should check the administration record to complete the first e-MAR transcription check and place initials in the e-MAR #1 box on the Physician's order form. The chart should be flagged for the next nursing shift to complete the second e-MAR transcription check. The registered staff member performing the second e-MAR check should place their initials in the e-MAR #2 box on the physician order form.

a. Review of resident #065's Physician's order forms showed an order from an identified date, ordering a medication dosage change written as discontinuing one dosage and ordering the new dosage of an identified medication.

Review of resident #065's MAR for the month in which the above medication dosage was changed showed an order initiated four days after the Physician's order was written ordering the new dosage of the identified medication. An additional order for the identified medication was initiated 10 days following the Physician's order being written, with the initial dosage of the identified medication being discontinued the same day.

Resident #065's Physician's order form was signed off in the Nurse #1 box by RN #137 on the same day as the Physician's order being written, and RN #136 signing Nurse #2 four days later. In an interview, RN #137 indicated they were expected to check the order to ensure it was transcribed by pharmacy onto the e-MAR prior to signing off on the Physician's order form but may have overlooked this step on the above mentioned date. In an interview, RN #136 indicated they were responsible to ensure the order had been transcribed into the e-MAR prior to signing off on the Physician's order form. RN #136 did not recall if they had entered the new dosage of the identified medication into resident #065's e-MAR four days after the Physician's order but stated they would not sign the Physician's order form without ensuring it was transcribed into the e-MAR.

In an interview, the DRC indicated that it was the home's expectation that registered staff adhere to the pharmacy provider's policies which were established as the home's

medication management policies. The DRC indicated that registered staff in the home were expected to ensure transcription by the pharmacy had taken place by checking the order against the resident’s e-MAR prior to signing off on the Physician’s order form. The DRC indicated that as RN #137 signed off on resident #065’s Physician’s order forms without ensuring the Physician's orde had been transcribed into the e-MAR, the home’s medication management policies were not complied with.

b. Due to identified noncompliance with O.Reg.79/10, s. 8. (1). b, the sample of residents reviewed was expanded to include resident #068.

Review of resident #068’s Physician's order forms showed an order written on an identified date, discontinuing a specified dosage of an identified medication and ordering the same medication at a new dosage. A subsequent telephone order was written two days later, changing the above identified medication back to the initial dosage.

Review of resident #068’s MAR from the month in which the above Physician's orders were written showed that as of the date of the first written Physician's order the above identified medication dosage was discontinued and the newly ordered dosage was initiated. The Physician's order changing the identified medication back to the initial dosage was not shown on the MAR.

Further review of resident #068’s Physician’s order form showed that for the telephone order changing the identified medication back to its initial dosage, RPN #132 signed off on the Nurse #1 box on the Physician’s order form three days after the order date. The Physician’s order form was signed off by RPN #138 in the Nurse #2 box. In interviews, RPNs #132 and #138 both indicated they were aware of the home’s protocol of ensuring transcription of Physician’s orders into the e-MAR prior to signing on the Physician’s order forms, but did not recall if this step had been taken prior to signing.

In an interview, the DRC indicated that RPNs #132 and #138 could not have checked that the Physician’s order had been transcribed onto the e-MAR by pharmacy onto resident #068’s e-MAR prior to signing off on the Physician’s order form and had not complied with the home’s medication management policies.

This evidence is further evidence to support Compliance Order (CO) #002 issued under inspection report 2018_493652_0015, served on January 14, 2019, order due date April 30, 2019. [s. 8. (1) (b)]

WN #4: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a. Review of resident #065’s Physician’s order forms showed an order from an identified date, ordering a medication dosage change written as discontinuing one dosage and ordering the new dosage of an identified medication.

Review of resident #065’s MAR for the month of the above Physician's order showed an order for the initial dosage of the above identified medication which continued past the above identified order date and was administered on five identified dates after the Physician discontinued the initial dosage.

In a telephone interview with the CEO of the home's pharmacy provider indicated that the pharmacy had not received the Physician's order for resident #065 as written on the above identified date, and did not receive it until receiving a facsimile (fax) copy of the order 10 days later. The pharmacy CEO indicated there may have been an issue with the electronic pen which sends Physician's orders to be transcribed by the pharmacy. The pharmacy CEO indicated that once receiving the Physician's order via fax the order was updated by pharmacy in resident #065’s MAR to reflect the above identified medication dosage change. The pharmacy CEO indicated that the staff of the home would be expected to verify the physician order form against the MAR before signing off on the physician order form in the Nurse #1 and Nurse #2 boxes.

In interviews, RN #133 and RPN #132 indicated they had administered the initial dosage of the identified medication for resident #065 on four of the five above mentioned identified dates, as this was the dosage indicated in the resident’s e-MAR at time of

administration. The registered staff indicated they were not aware of the change in medication dosage on those dates and only administered what was indicated in the e-MAR.

b. Due to identified noncompliance with O.Reg.79/10, s. 131 (2), the sample of residents reviewed was expanded to include resident #068.

Review of resident #068's Physician's order forms showed an order written on an identified date, discontinuing a specified dosage of an identified medication and ordering the same medication at a new dosage. A subsequent telephone order was written two days later, changing the above identified medication back to the initial dosage.

Review of resident #068's MAR from the month in which the above Physician's orders were written showed that as of the date of the first written Physician's order the above identified medication dosage was discontinued and the newly ordered dosage was initiated. The Physician's order changing the identified medication back to the initial dosage was not shown on the MAR. In an interview, Pharmacy representative #140 indicated that the telephone Physician's order changing the identified medication back to its initial dosage, had never been received by the pharmacy.

In an interview, RN #127 indicated that it appeared that the telephone Physician's order for resident #068 may have not been written using the electronic pen and would have not been transmitted to pharmacy as a result. RN #127 indicated that resident #068 had been administered the incorrect dosage of the identified medication since the telephone Physician's order was written.

In an interview, the DRC indicated that for residents #065 and #068 that physician orders were written in the physician order forms indicating instructions for administration by the prescriber. The DRC acknowledged that for residents #065 and #068 the home had failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

This evidence is further evidence to support CO #007 issued under inspection report 2018_493652_0015, served on January 14, 2019, order due date April 30, 2019. [s. 131. (2)]

Issued on this 10th day of April, 2019

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

Original report signed by the inspector.