Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 28, 2021	2021_780699_0018	011407-21	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

PRAVEENA SITTAMPALAM (699)

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): September 29, Oct 1, 5-8, and 12, 2021.

The following intake was completed in this compliant inspection:

Log #011407-21 related to medication incident and plan of care.

Inspector Stephanie Luciani (#707428) attended this inspection on orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Nurse Practitioner (NP), Resident Care Manager (RCM), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 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 staff participated in the implementation of the infection prevention and control program.

The inspector observed the following while conducting a tour of the home:
-observed staff entering a resident room, with signage indicating the resident was droplet precaution. Staff did not wear a gown, face shield or gloves. They were less than 6 feet from the resident, assisting the resident after the meal service. The staff did not complete hand hygiene after the interaction;
-observed staff not completing hand hygiene between assisting residents with their meal and after handling used plates and cutlery; and
-observed staff applying aprons on residents without completing hand hygiene between residents.

Staff were expected to wear an isolation gown, face shield, surgical mask and gloves when entering a droplet contact isolation room. Staff were also expected to complete hand hygiene after every resident interaction, handling used plates and cutlery and upon donning and doffing personal protective equipment.

Sources: Observations, and staff interviews. [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 IPAC program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of a resident's medication incident.

A complaint was received by the Ministry of Long-Term Care (MLTC) related to a medication incident involving a resident.

On a specified date, the resident did not receive two of their scheduled medications. There was no documentation of the medication incident in the resident's chart. The RPN indicated that they had completed a medication incident report and submitted it to the on-call manager. The home was unable to provide the inspector a record of the medication incident.

Sources: The resident's clinical health record, medication administration record (MAR), and staff interviews. [s. 135. (2)]

Issued on this 29th day of October, 2021

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

Original report signed by the inspector.