

# 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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	Licensee Copy/Copie du Titulair	re Public Copy/Copie Public		
Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection		
January 31, 2011, April 18, 2011 & May 9, 2011	2011_116_2954_31Jan094043	Critical Incident Log# T3167		
Licensee/Titulaire				
Advent Healthcare Corporation				
Long-Term Care Home/Foyer de soins de longue durée				
Valleyview Residence, 541 Finch Avenue West, Toronto ON, M2R 3Y3				
Name of Inspector/Nom de l'inspecteur				
Saran Daniel-Dodd, Nursing Inspector				
Inspection Summary/Sommaire d'inspection				
The purpose of this inspection was to conduct a critical incident inspection regarding alleged visitor to resident abuse.				
During the course of the inspection, the inspector spoke with:  The Administrator  Director of Care Family & Resident Worker Registered and Direct Care Staff Members Resident's Substitute Decision Maker  During the course of the inspection, the inspector: Reviewed health record of a resident Reviewed the homes abuse policy				
The following Inspection Protocols were to	used in part or in whole during thi	s inspection:		
Prevention of Abuse and Neglect				
Findings of Non-Compliance were	e found during this inspection.	The following action was taken:		
3 WN				



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#### NON- COMPLIANCE / (Non-respectés)

#### Definitions/Définitions

(April 1

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 à 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. 20 (2) (d).

At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, d) shall contain an explanation of the duty under section 24 to make mandatory reports.

#### Findings:

Licensee policy to promote zero tolerance of abuse and neglect of residents (Policy # NM-II-R005) does not include an explanation of the duty under section 24 to make mandatory reports.

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#### WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 s. 24 (1) 2.

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:

2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

#### Findings:

- An alleged sexual abuse involving a resident was reported to staff members and was not reported to the Director as required. No action was taken by the licensee as a result of this incident.
- A further incident of alleged sexual abuse occurred involving same resident was reported to staff members. Action was taken by the home in regards to this incident.

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WN #3: The Licensee has failed to comply with O.Reg. 79/10 s.96. (c), (e).  Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (c) identifies measures and strategies to prevent abuse and neglect (e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations.	
<ul> <li>Policy NM-II-R005 to promote zero tolerance of abuse and neglect of residents does not stipulate measures and strategies for staff to reduce potential of abuse.</li> <li>Policy NM-II-R005 to promote zero tolerance of abuse and neglect of residents does not contain required training and retraining requirements for all staff members.</li> <li>Policy to promote zero tolerance for abuse and neglect (NM-II-R005) does not contain required training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.</li> </ul>	
Inspector ID#: 116	

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.
	Dan Dodr.
Title: Date:	Date of Report: (if different from date(s) of inspection).
	May 9, 2011