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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date June 10, 2022
Inspection Number 2022_1437_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Advent Health Care Corporation

Long-Term Care Home and City
Valleyview Residence, 541 Finch Avenue West, North York, ON, M2R3Y3

Inspector who Amended
April Chan (ID#704759)

Inspector who Amended Digital Signature
April W Chan
Digitally signed by April W Chan
Date: 2022.07.05 10:55:34 -04'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect the correct legislative reference and sources for Non-compliance (NC) #01. The Complaint and Follow-Up inspection, 2022_1437_0001, was completed on May 11 - 13, 16, and 17, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 11 - 13, 16, and 17, 2022.

The following intake were inspected:

- Intake # 020492-21 related to multiple alleged care concerns.

The following follow-up intake were inspected:

- Intake # 017373-21 related to complying with the home's policy and procedures.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

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Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 8 (1)	2021_780699_0019	001	Adelfa Robles (#723)

The following **Inspection Protocols** were used during this inspection:

- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services
- Responsive Behaviours

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (2) (b)

On May 11, 2022, inspector observed two resident rooms with droplet contact precautions signage with its personal protective equipment supplies at the point of care lacked supply of face masks. Registered staff on the floor and IPAC lead agreed that face masks should be supplied and made available at the caddy hanging outside the resident's door for caregivers to access.

May 13, 2022, the above-mentioned resident rooms under droplet and contact precaution was supplied with a box of surgical mask inside the yellow caddy.

Sources: observations on May 11, 13, 2022, and interviews with RPN #110 and IPAC lead.

Date Remedy Implemented: May 13, 2022 [704759]

WRITTEN NOTIFICATION POLICIES AND RECORDS

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: s. 11 (1) (b) of O. Reg. 246/22 under the FLTCA.

The licensee has failed to ensure that the home's policy titled Weight And Height Management effective September 5, 2017 is complied with.

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding inadequate nutritive care leading to significant weight loss.

Rationale and Summary
The home's policy on Weight and Height Management stated that the registered staff member was responsible to ensure all residents' weights are compared to last month's, prior to documentation. The resident was to be re-weighed immediately if the difference is greater than 5% to ensure accuracy.

A resident's weight on a specific date had decreased by 15.9% compared to prior month. Interviews with direct care staff and registered staff indicated that they were not aware of the significant difference in weight and stated that the resident was to be reweighed or the need for a reweigh was to be communicated to the incoming shift. The resident was reweighed on a later date and new records show that there was not a significant change from the previous month.

Sources: the LTCH's policy titled Weight And Height Management effective September 5, 2017, clinical records of the resident, interviews with registered staff and other staff. [r. 11 (1) (b)] (704759)

WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 r. 53 (1) (1)

The licensee has failed to ensure that there were written approaches to care for a resident, including identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, or other.

A complaint was received by the MLTC alleging neglect regarding management of the resident's responsive behaviour.

Rationale and Summary
The resident had a history of a specific behaviour. Staff identified that potential behavioural triggers included toileting needs, or other physical needs. Staff identified that during the later part of the day and at night the specific behaviour occurs more frequently. Behaviours were altered by offering to attend to their physical needs, redirection, and reapproaching. The home implemented a specific intervention for the resident at nighttime.

The resident's written plan of care did not identify potential behavioural triggers. Resident care manager and registered staff agreed that interventions and identified triggers specific to the resident should be included in the care plan.

By failing to ensure that triggers are identified within the written approaches to care, the resident had a potential risk of their care needs not being met.

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Sources: progress notes, clinical records, and care plan for the resident, interview with the complainant, interviews with direct care staff, a Resident Care Manager and other staff. [s. 53 (1) (1)] (704759)