Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 27, 2023	
Inspection Number: 2023-1437-0003	
Inspection Type: Critical Incident System	
Licensee: Advent Health Care Corporation	
Long Term Care Home and City: Valleyview Residence, North York	
Lead Inspector Ryan Randhawa (741073)	**Inspector Digital Signature** Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2023.03.01 15:07:37 -05'00'
Additional Inspector(s) Adam Dickey (643) was present during this inspection as an assessing mentor	

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 14-16, 21, 2023, conducted on-site and February 17, 2023, conducted off-site.

The following intake(s) were inspected:

- Intake: #00019682 [CI: 2954-000005-23] was related to falls prevention and management

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

Infection Prevention and Control
Falls Prevention and Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

A resident's care plan did not reference the resident's use of a mobility aide in the mobility section. An RPN indicated that the resident started to use the mobility aide in January 2023.

The RPN stated that the nursing team was responsible for updating the care plan to reflect changes in resident care needs. The intervention for the mobility aide was revised in the care plan under the mobility section on February 16, 2023.

By not having the required mobility aide in the care plan under the mobility section, the risk of the resident sustaining a fall was increased.

Sources: Resident's care plan, interview with RPN

Date Remedy Implemented: February 16, 2023
[741073]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that the infection prevention and control (IPAC) lead carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that that there is in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022". Specifically, the IPAC lead did not ensure the hand hygiene program includes 70-90% alcohol-based hand rub as is required by Additional Requirement 10.1 under the IPAC Standard.

During observations, alcohol-based hand rub (ABHR) bottles containing 62% alcohol were noted at the front reception desk and a resident home area. The RPN indicated that ABHR of less than 70% would not

be as effective to kill viruses and bacteria.

After the IPAC Lead was notified of the observations, ABHR of less than 70% were no longer observed during the remainder of the inspection. There was low risk to residents as there were other ABHR found at the front desk and the resident home area with at least 70% alcohol.

Sources: Observations on a resident home area and front reception desk on February 14, 2023; interview with RPN and IPAC Lead.

Date Remedy Implemented: February 16, 2023
[741073]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

The home has failed to ensure that Routine Practices were implemented in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene, including the four moments of hand hygiene, as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

During observations on a resident home area, a PSW assisted two residents with their clothing protectors and then another resident with their meal without performing hand hygiene in between resident interactions.

The PSW confirmed that they forgot to perform hand hygiene after contact with the residents they assisted in the dining room.

There was a risk of infection transmission when the PSW did not perform hand hygiene under routine practices.

Sources: Observations on a resident home area; and interview with PSW.

[741073]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that the infection prevention and control (IPAC) lead carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that there is in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" as it related to hand hygiene practices and ensuring all hand hygiene agents contain 70-90% alcohol.

Rationale and Summary

During observations, staff were observed performing hand hygiene for residents that entered the dining room on a resident home area. The product used was "Personal Care Wipes" located in a wall-dispenser beside the entry of the dining room. The product description indicated that the product did not contain any alcohol. The housekeeper confirmed that there was no alcohol in the product that was being used for hand hygiene.

The use of hand hygiene products without alcohol compromised the effectiveness of the home's hand hygiene program. The IPAC Lead acknowledged that there was risk to residents when staff used wipes with no alcohol content for hand hygiene as the wipes may not prevent the transmission of infection.

Sources: Observations; interview with the housekeeper and IPAC lead.

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