Ontario

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

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

Toronto District
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Original Public Report

Report Issue Date: December 7, 2023
Inspection Number: 2023-1437-0006
Inspection Type: Complaint Critical Incident Follow up
Licensee: Advent Health Care Corporation
Long Term Care Home and City: Valleyview Residence, North York
Lead Inspector Reji Sivamangalam (739633)
Inspector Digital Signature
Additional Inspector(s) Irish Abecia (000710)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 23 -24, 27-30, 2023 and December 1, 2023

The following intake(s) were inspected:

- Intake: #00097089 - Critical Incident System (CIS) #2954-000030-23 related to fall prevention and management.
- Intake: #00098292 - Follow-up #: 1 - O. Reg. 246/22 - s. 40
- Intake: #00098293 - Follow-up #: 1 - O. Reg. 246/22 - s. 102 (8)
- Intake: #00099033 - CIS #2954-000032-23 related to infection prevention and control

- Intake: #00099691 - CIS #2954-000035-23 related to potential neglect
- Intake: #00099695 - CIS #2954-000034-23 related to improper care
- Intake: #00100387 - Complaint related to infection prevention and control
- Intake: #00100979 - Complaint related to improper care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1437-0005 related to O. Reg. 246/22, s. 40 inspected by Irish Abecia (000710)

Order #002 from Inspection #2023-1437-0005 related to O. Reg. 246/22, s. 102 (8) inspected by Irish Abecia (000710)

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

Resident Care and Support Services
Infection Prevention and Control
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights

of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that the residents' right to have their Personal Health Information (PHI) within the meaning of the PHI Protection Act, 2004 was kept confidential in accordance with the Act and was fully respected and promoted.

Rationale and Summary

A registered staff member was observed administering medications to residents in a home area. The medication cart was left unattended with the record screen unlocked. A visitor was observed looking at the screen as the medication cart remained unattended.

The staff member confirmed that the screen should have been locked and the visitor should not have had access to residents' information. Resident Care Manager (RCM) confirmed that staff were expected to lock the record screen when leaving the medication cart unattended to ensure that residents' privacy and information were protected.

Failure to ensure that the record screen was kept locked with residents' information protected breached their rights to privacy and confidentiality.

Sources: Observations and interviews with staff members.

[000710]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff members collaborated with each other in assessing a resident's footcare.

Rationale and Summary

The resident's plan of care indicated that staff members were to provide specific footcare on bath days. The Ministry of Long-Term Care (MLTC) received a complaint that the resident's specific footcare was not appropriately provided, and the resident developed a health condition.

A staff member stated that they had increased difficulty providing specific footcare but continued to provide it. The registered staff verified that staff members did not inform them about the difficulty in providing the resident's footcare. The RCM acknowledged that the staff members should have informed the registered staff about the difficulty in providing the resident's foot care when it was noticed and that there was a delay in reporting it to the registered staff. The administrator acknowledged the lack of communication between the staff members about the resident's foot care.

Failure to provide effective and timely foot care to the resident placed them at an increased risk for injury and infection.

Sources: The home's Nail Care policy, resident's clinical records, Critical Incident System (CIS) report, interviews with staff members.

[739633]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the staff documented the foot care to a resident.

Rationale and Summary

The resident’s plan of care indicated that staff members are to provide specific foot care to the resident on bath days and as required. The home's policy directed staff to document in the resident's electronic health record when they provided foot care.

The staff’s documentation records did not include the provision of specific foot care to a resident for a certain period. The staff member stated that the foot care provided was not documented. The RCM verified that the staff members were not documenting the foot care service provided to the resident.

The administrator acknowledged that the staff were expected to document the provision of foot care.

Failure to document the foot care provided to the resident placed them at risk for compromised continuity of care.

Sources: The home's Nail Care policy, resident's clinical records, interviews with staff members.

[739633]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident's plan of care related to foot care was reviewed and revised when the staff could no longer provide the specific foot care properly.

Rationale and Summary

The resident's plan of care indicated staff are to provide specific foot care to the resident on bath days and as required. MLTC received a complaint that the resident's specific foot care was not provided properly, and the resident developed a health condition.

The staff member stated that they were having increased difficulty in providing the specific foot care but continued to provide it. Registered staff and RCM acknowledged that the resident's foot care was not properly provided. The RCM stated that a referral for specialized foot care services should have been initiated and that the plan of care was not revised. The registered staff acknowledged a delay in referring the resident to the foot care nurse. The administrator

acknowledged that the staff were required to review and revise the plan of care when the resident's care needs changed.

The resident was at risk of developing infection and experience discomfort when their foot care was not properly provided.

Sources: The home's Nail Care policy, resident's clinical records, CIS report, interviews with staff members.

[739639]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

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 was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, Revised September 2023". Specifically, the IPAC lead failed to ensure that the hand sanitizing wipes used for assisting residents to perform hand hygiene before meals included 70-90% Alcohol-Based Hand Rub (ABHR) as required by Additional Requirement 10.1 under the IPAC standard.

Rationale and Summary

On a specific date, staff were observed assisting residents with hand hygiene using hand sanitizing wipes prior to meal service. A staff member confirmed that they used the hand sanitizing wipes to assist residents with hand hygiene before and after meal service.

The hand sanitizing wipe's product label had shown that it contained no alcohol content. The IPAC Lead confirmed that the hand sanitizing wipes did not contain any alcohol and therefore did not meet the requirements of the IPAC standard.

Failure to ensure that the hand sanitizing wipes included 70-90% ABHR when assisting residents with hand hygiene prior to meal service increased the risk of infection transmission.

Sources: Observations, interviews with staff members

[000710]