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
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: May 6, 2024

Inspection Number: 2024-1437-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Advent Health Care Corporation

Long Term Care Home and City: Valleyview Residence, North York

Lead Inspector	**Inspector Digital Signature**
Manish Patel (740841)	Manishkumar C Patel Digitally signed by Manishkumar C Patel Date: 2024.05.09 12:29:32 -04'00'

Additional Inspector(s)
Oraldeen Brown (698)
William Farr (000857) and Rachel Dioquino (000856) were present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 28, 2024 and April 3 - 5, and 8 - 10, 2024

The following intake(s) were inspected:

- Intake: #00103613 / CIS #2954-000037-23, and Intake: #00105361 / CIS #2954-000040-23 - related to outbreak
- Intake: #00106872 / CIS #2954-000001-24, Intake: #00108182 / CIS #2954-000005-24, and Intake: #00108289 / CIS #2954-000006-24 - related to fall from resident resulting in injury
- Intake: #00110144, and Intake: #00111012 - related to complainant related to

abuse, bedtime and rest routines, administration of drugs and discharge

- Intake: #00111455 / CIS #2954-000015-24 - related to abuse from PSW towards resident.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) 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.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm has occurred or may occur, shall report the suspicion and the information upon which it is based to the Director immediately.

Rationale and Summary

A resident had altered skin integrity to their hand. The resident informed the staff that the injury occurred when a staff member asked them to go to the washroom but they refused to go and that's when the staff held onto them and they resisted, which resulted in an injury. This injury was noted by a family member, visiting the resident after two days of the incident, who brought it to another staff's attention. In absence of any follow-up, the family member approached the Registered Practical Nurse (RPN) after two more days, inquiring about the outcome of the follow-up, which resulted in home calling the after-hours line to inform the Director of allegation of staff to resident abuse; four days after the incident.

RPN acknowledged that there was no documentation or communication available in the resident's chart about any incident or injury. Nurse manager acknowledged that the allegation of abuse should have been reported to the Director on the day it was first brought to the staff's attention.

The home's 'Abuse and Neglect' policy identified that staff must immediately report their suspicion of abuse to the home and to the Director. Based on the review of the resident's progress notes and assessments, it was noted that no action was taken by nursing staff, initially and subsequently, when the allegation was brought to the staff's attention.

Failure to report the Director immediately of suspected abuse put the resident at risk of harm due to delayed interventions and investigation.

Sources
Review of 'Abuse and Neglect' policy, Resident's progress notes and assessments, interview of RPN and Nurse Manager.
[740841]

WRITTEN NOTIFICATION: General Requirements for Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to keep a written record related to falls prevention and management program evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation and the date those changes identified with program evaluation were implemented.

Rationale and Summary
Review of Falls prevention and management program evaluation noted that the program evaluation was completed in "February, 2023", but it did not identify exact date the program evaluation was completed. Also, the program evaluation did not identify names of the persons who participated in the evaluation and the date the

changes identified with the program evaluation were implemented.

Falls Prevention Program Lead acknowledged that the program evaluation did not have the date of the evaluation, the names of the persons who participated in the evaluation, and the date that the changes identified with the program evaluation were implemented.

Failure to keep written record related to falls prevention and management program evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation and the date that changes were implemented, did not impact health or well being of residents negatively.

Sources
Review of falls prevention and management program evaluation and interview with the program lead.
[740841]

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to make the report after normal business hours, of an outbreak of a disease of public health significance or communicable disease, using

the Ministry's method for after hours emergency contact.

Rationale and Summary
Upon review of a Critical Incident System (CIS), it was noted that Toronto Public Health had declared outbreak of infectious disease on December 29, 2023. A CIS report was submitted by the home after normal business hours on December 29, 2023 at 6:11 PM, informing the Director of the outbreak. The home did not use the Ministry's method for after-hours emergency contact.

the Infection Prevention and Control (IPAC) Lead and the Administrator acknowledged that for CIS; after-hours emergency contact method was not utilized.

Failure of the home to report an outbreak of a disease of public health significance or communicable disease, using the Ministry's method for after hours emergency contact, could have delayed the Director's ability to respond to the incident in a timely manner.

Sources
Interview of the IPAC Lead and Administrator, Review of CIS.
[740841]

WRITTEN NOTIFICATION: Requirements on Licensee before discharging a resident

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

The licensee failed to collaborate with the appropriate placement coordinator to make alternative arrangements for the accommodation, care and secure environment required by a resident before discharging resident.

Rationale and Summary
A resident was discharged from the home following a transfer to the hospital.

The resident's clinical records showed that the home had offered the resident assistance in finding alternate accommodations which the resident had declined.

Progress notes, documented that the resident was sent by the physician to the hospital for a specific evaluation. A specific form, indicated that the resident had been discharged and the resident should not be sent back to the home. On the same day, the home's progress notes indicated that the hospital attempted to transfer the resident back but the home refused the resident's return, informing the hospital that the resident had been discharged.

The resident was discharged from the home based on the leaderships' decision that the resident's care needs had changed and that the home could no longer provide care safely to the resident. No evidence was provided by the home to indicate that confirmed alternate accommodation arrangements have been made for the resident in which their needs would be met in a safe and secure manner. The Administrator acknowledged that the day before the resident's discharge, there was no plan to discharge them.

The Resident stated that they were told that they were being sent for a specific evaluation and that they are being discharged from the home prior to being transferred to hospital.

Manager of Home and Community Care Support Services (HCCSS) acknowledged that there was no actual discharge plan with confirmed alternate accommodations following discharge from the home for the resident due to the resident's refusal to provide consent for any alternate accommodation arrangements in order to move the discharge forward.

Failure to provide alternate accommodations for the resident in which they would be provided with care and secure environment prior to discharging them from the home placed them at an increased risk for compromised health and wellbeing.

Sources: Resident's health records, interview with the resident, Administrator, Physician, Manager of HCCSS, RFRC and other relevant staff.
[698]

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge

the resident.

The licensee failed to provide a written notice to a resident, or any person the resident may direct, before the resident's discharge from the home in accordance with regulatory requirements.

Rationale and Summary
A Resident was sent to the hospital for a specific evaluation, and was discharged from the home on the same day.

The home's policy, titled "Discharge of a Resident," outlined that the Administrator/Director of Care/designate must provide written notice to the resident and / or the resident's Substitute Decision Maker (SDM) which includes a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements of care, that justify the home's decision to discharge the resident, which aligns with the regulatory requirements.

A review of the resident's clinical records showed no information that a written notice was provided to the resident about the discharge. The resident's clinical records showed documentation of the home discussing the resident's discharge or potential discharge from the home. Documentation showed that the resident was offered assistance to find another place to live, however the resident, who was their own Power of Attorney (POA) declined.

The Administrator acknowledged that a written notice of the resident's discharge was not provided to the resident prior to, or after the resident had been discharged from the home.

By not providing a written notice to the resident and whomever they may direct, the

resident was not provided the opportunity to take part in their discharge planning, or to find appropriate supports towards discharge.

Sources: Resident's health records, policy titled "Discharge of a Resident, and interview with the Administrator.
[698]