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: July 08, 2024
Inspection Number: 2024-1437-0003
Inspection Type: Critical Incident
Licensee: Advent Health Care Corporation
Long Term Care Home and City: Valleyview Residence, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 10 - 14, 17, 20, 21, 24, 25, 2024.

The following Critical Incident System (CIS) intake(s) were inspected:

• Intake: #00107112 (CIS #2954-000003-24) – Related to improper care;
• Intakes: #00110081 – (CIS #2954-000010-24) and #00110718 – (CIS #2954-000011-24 – Related to alleged neglect;
• Intake: #00116090 – (CIS #2954-000018-24) - Related to infection prevention and control.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that residents' written plan of care sets out clear directions for staff and others who provided direct care to the residents.

Rationale and Summary

1) On June 10, 2024, a resident was in bed without an intervention their care plan indicated that they required while in bed.

A Personal Support Worker (PSW) stated that the intervention was no longer required for the resident. A Registered Practical Nurse (RPN) confirmed that the intervention was discontinued, and the plan of care was not updated.

Failure to ensure the written plan of care for the resident sets out clear directions to staff posed a risk of gaps in services provided to the resident.

On June 14, 2024, the intervention was removed from the resident's care plan.

Sources: Observation; resident's clinical records; interviews with staff.

Date Remedy Implemented: On June 14, 2024
[000860]

Rationale and Summary

2) A treatment device was applied for a resident while in bed on the morning of June 20, 2024. The resident's care plan indicated that the device should have been applied 24 hours a day and seven days a week. The resident's eMAR (Electronic Medical Records) indicated that the device should have been worn at "nighttime when in bed only and removed every morning at bedtime and removed per schedule".

A RPN and a Resident Care Manager (RCM) acknowledged that the directions provided to staff related to the application of the treatment device were unclear.

Failure to provide clear directions to staff regarding the use of a treatment device posed no risk to the resident.

A physician order to apply the treatment device 24 hours a day on every shift was initiated on June 20, 2024.

Sources: Observations; resident's clinical records; and interviews with staff.

Date Remedy Implemented: June 20, 2024
[000860]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provided direct care to residents had convenient and immediate access to their plan of care.

Rationale and Summary

1) On June 10, 2024, a printed copy of treatment recommendations were posted in a resident's room. The recommendations were not included in the resident's care plan and kardex.

A PSW stated that they relied on the written care plan and Kardex to provide directions for resident care. They confirmed that the recommendations were not in the resident's Kardex or care plan and they did not have convenient and immediate access to it. The RCM stated that the recommendations should have been included in the resident's care plan.

Failure to ensure that staff and others who provided direct care to a resident had convenient and immediate access to the treatment recommendations may have increased the risk of staff not providing appropriate care to the resident.

On June 24, 2024, the treatment recommendations were updated in the resident's care plan and Kardex.

Sources: Observations; resident's clinical records; and interviews with staff.

Date Remedy Implemented: On June 24, 2024
[000860]

Rationale and Summary

2) A transfer schedule posted in a resident's room on June 10, 2024, was not included in the resident's care plan.

Four staff members confirmed that the transfer schedule should have been included in the resident's care plan for convenient and immediate access.

Failure to provide staff with convenient and immediate access to the resident's transfer schedule may have increased the risk of staff not providing correct care to the resident.

On June 20, 2024, the resident's care plan was updated with the resident's transfer schedule.

Sources: Observations; resident's clinical records; interviews with staff.

Date Remedy Implemented: June 20, 2024
[000860]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified.

Rationale and Summary

A resident required total assistance with eating. A PSW served the resident a hot beverage in their room and left them unattended, resulting in an injury.

The PSW acknowledged that they did not review the resident's care plan and were unaware they required total assistance with eating. A Registered Nurse (RN) verified that the resident should not have been left unattended with the hot beverage.

Staff failure to follow the care set out in the resident's plan of care resulted in an injury to the resident.

Sources: Review of the Critical Incident Report, resident's clinical records, the home's investigation notes; and interviews with staff
[741670]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 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 had reasonable grounds to suspect neglect of a resident by someone that resulted in harm or risk or harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

A written complaint related to multiple incidents of a resident's call bell being inaccessible was received by the home on a specified day. A Critical Incident (CI) report alleging neglect of the resident related to the incidents was submitted to the Ministry after hours on the same day. The Ministry of Long-Term Care (MLTC) after hours number was not contacted.

The Administrator acknowledged that the MLTC after hours number should have been contacted to report to the Director.

Failure to contact the MLTC after hours number to report alleged neglect of a resident to the Director had low impact on the resident.

Sources: Review of Critical Incident Report; and interview with the Administrator. [741670]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that a written response provided to a person who made a complaint to the licensee concerning alleged neglect of a resident included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

A written complaint regarding alleged neglect of a resident was received by the licensee. The home responded to this complaint in writing.

The response letter did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

The home's Administrator acknowledged that the MLTC and Patient Ombudsman information should have been included in the response letter sent to the complainant.

Sources: Review of Critical Incident Report; and interview with the Administrator. [741670]

WRITTEN NOTIFICATION: Administration of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A physician order was given for a medication after a resident sustained an injury. The new order was not administered to the resident for two days.

A RPN acknowledged that the physician's order should have been transcribed immediately and the medication administered to the resident starting the following day. The RCM acknowledged that the home did not follow the physician's order as prescribed.

Failure to administer medication to a resident in accordance with the directions for use specified by the physician may have resulted in the resident's condition not being managed effectively.

Sources: Review of resident's clinical records; and interview with staff.
[741670]