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

Public Report

Report Issue Date: May 15, 2025

Inspection Number: 2025-1437-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Advent Health Care Corporation

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 5-8, 13-15, 2025
The inspection occurred offsite on the following date(s): May 9, 2025

The following intake(s) were inspected:

- Intakes: #00139319 and #00139320 - Follow-ups related to plan of care.
- Intakes: #00139460/Critical Incident System (CIS) #2954-000006-25 and #00140845/CIS #2954-000010-25 were related to infection outbreaks.
- Intake: #00144564/CIS #2954-000016-25 was related to alleged abuse of a resident.
- Intakes: #00144788/CIS #2954-000017-25 and #00145102/CIS #2954-000019-25 were related to fall prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1437-0001 related to FLTCA, 2021, s. 6 (4) (a)

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Order #002 from Inspection #2025-1437-0001 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect was promoted in a way that fully recognized their dignity and individuality, specifically when a Personal Support Worker (PSW) rushed their care and used a disrespectful tone.

Sources: Long-Term Care Home's (LTCH's) investigation records; interviews with

the PSW and Administrator.

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
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; and

The licensee has failed to ensure that the PSW collaborated with nurses in the assessment of a resident when they failed to notify the nurse of a change in the resident's health condition.

Sources: Resident's clinical record, home's investigation notes; interviews with the PSW, Resident Care Manager (RCM) and Administrator.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that the PSW used a safe transfer technique when transferring a resident. As per the resident's plan of care, they required a specific transfer method due to an elevated risk of injury associated with their health

condition, however this method was not followed by the PSW.

Sources: Resident's clinical record; and interview with the PSW.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their Falls Prevention & Management Program policy after a resident's fall, when two PSWs and a Registered Practical Nurse (RPN) moved and manually transferred a resident when they experienced a change in their health condition.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with.

Specifically, according to the home's policy, if there was suspicion or evidence of injury, the resident should not have been moved. Additionally, when the registered staff determined that the resident was safe to be transferred, a specific transfer method was to be used.

Sources: Home's Fall Prevention & Management Program Policy, resident's clinical records; and interviews with the PSWs, RPN, Registered Nurse (RN) and RCM.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when a confirmed disease outbreak was declared by Public Health. The Infection Prevention and Control (IPAC) Lead confirmed that the CIS report was not immediately reported to the Director.

Sources: CIS; and interview with the IPAC Lead.