

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: February 17, 2026

Inspection Number: 2026-1437-0002

Inspection Type:

Complaint
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 date(s): February 4 to 6, 9 to 12, 17, 2026

The following intake(s) were inspected in this Critical Incident (CIS) inspection:

-Intake: #00166549 - CIS# 2954-000050-25; Intake: #00167138 - CIS #2954-000001-26 - related to Outbreak Management
-Intake: #00168314 - CIS #2954-000002-26 - related to Prevention of Abuse and Neglect

The following intake(s) were inspected in this Complaint inspection:

-Intake: #00168379 - Complaint related to Prevention of Abuse and Neglect
-Intake: #00168588 - Complaint related to Safe and Secure Home and Resident Care and Services

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

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,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A resident's Power of Attorney (POA) refused a treatment and emailed the Resident Care Manager (RCM) on an identified date. Despite this, the resident received the treatment weeks later. The RCM acknowledged that they did not collaborate with the clinic, Nurse Practitioner (NP), or registered staff to ensure the plan of care related to the refusal was implemented.

Sources: Review of a resident's clinical records, home's investigation notes, POA's email, and interviews with the RCM and NP.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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.

(i) A resident's plan of care indicated a specific level of assistance for toileting care. On an identified date, a Personal Support Worker (PSW) did not provide the indicated level of assistance required for toileting care.

Sources: Review of a resident's clinical records, video footage review, and interviews with the RCM, Director of Resident Care (DRC), and other staff.

(ii) A resident's plan of care specified their personal care and toileting preference. On an identified date, the resident's indicated personal care and toileting preference was not

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provided to them.

Sources: Review of a resident's clinical records, video footage review, and interviews with the RCM, DRC and other staff.

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)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with Addition Requirement 10.4 (h, i) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022, revised September 2023), the hand hygiene program should include support for residents to perform hand hygiene prior to receiving meals and snacks, and residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

A PSW did not offer or assist two residents in completing hand hygiene prior to eating their meal and acknowledged the same.

Sources: Inspector's observations, IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023), home's hand hygiene policy, and interviews with a PSW and IPAC Lead.

WRITTEN NOTIFICATION: Notification Re: Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (2)

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Notification re incidents

s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

A resident's Power of Attorney (POA) reported an allegation of abuse of the resident by a staff member to the home. The home completed an investigation and did not notify the POA if the allegations were substantiated or unsubstantiated.

Sources: Review of Critical Incident System (CIS) report, home's investigation file, home's response letter, home's Abuse and Neglect policy, and interviews with the DRC and RCM.