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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Original Public Report

Report Issue Date: April 14, 2023
Inspection Number: 2023-1437-0004
Inspection Type: Complaint Critical Incident System
Licensee: Advent Health Care Corporation
Long Term Care Home and City: Valleyview Residence, North York

Lead Inspector	**Inspector Digital Signature**
Reji Sivamangalam (739633)	Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2023.04.26 11:29:33 -04'00'

Additional Inspector(s)
Inspector Lisa Salonen Mackay (000761) was present during the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 23, 24, 28-30, 2023 and April 3 and 4, 2023
The inspection occurred offsite on the following date(s): March 27, 2023

The following intake(s) were inspected:
- Intake #000021208 (complaint) related to a fall prevention and management
- Intake #00083967 (complaint) related to alleged abuse.
- Intake #00022274 [Critical Incident System (CIS) #2954-000010-23, related to alleged abuse.

The Following intake (s) were completed:
- Intakes: #00020687 (CIS #2954-000007-23), #00021164 (CIS #2954-000008-23), and #00022250 (CIS #2954-000009-23) were related to fall prevention and management

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by a visitor.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain".

Rationale and Summary

(i) The resident was cognitively impaired. Staff observed a visitor physically abusing the resident. The Administrator and Resident Care Manager stated that the home's investigation confirmed that the visitor physically abused the resident.

Sources: Home's policy of Prevention of Abuse and Neglect, the resident's progress notes and clinical records, CIS report, and interview with staff members.

[739633]

The licensee has failed to ensure that a resident was protected from emotional abuse by a visitor.

Section 2 of the Ontario Regulation 246/22 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident"

Rationale and Summary

(ii) A staff member reported that they observed a visitor emotionally abusing a resident inside their room. The Administrator and Resident Care Manager stated that the home investigated the incident and confirmed that the visitor emotionally abused the resident.

Sources: The resident's clinical records and progress notes, Home's policy of Prevention of Abuse and Neglect, interview with PSW, RPN, Resident Care Manager and Administrator.

[739633]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that the Director was immediately informed regarding the emotional abuse of a resident.

Rationale and Summary

A staff member observed that a visitor emotionally abused a resident inside their room and reported it to the home. Resident Care Manager and Administrator confirmed that the visitor emotionally abused the resident. The Administrator acknowledged that the home was expected to submit a Critical Incident System (CIS) report to the Director about the incident, and a report was not submitted.

Sources: Home's policy of Prevention of Abuse and Neglect, the resident 's clinical records and progress notes and interview with Administrator and Resident Care Manager.

[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 (4) (a)

The licensee has failed to ensure that staff and others collaborated with each other to assess a resident's vital signs.

Rational and Summary

A resident was found to have a change in their health status; staff informed the physician and was ordered to take vitals twice daily and inform of any abnormalities. The resident had a fall on the next day. Resident Care Manager verified two instances of abnormal vital readings, and the physician was not

informed. Resident Care Manager and Clinical Service Manager acknowledged that staff were expected to notify the physician when abnormal vital signs were recorded.

There was a risk to the resident's health when the staff did not collaborate with the physician on the resident's vital signs.

Sources: The resident's clinical records, interview with Resident Care Manager and Clinical Service Manager

[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 (4) (b)

The licensee has failed to ensure that staff members collaborated to provide an intervention of an afternoon snack to a resident.

Rationale and Summary

The dietitian ordered a resident to receive a specific intervention for their afternoon snack, and it was included in the resident's written plan of care. The resident was not observed to receive the required intervention for their afternoon snack on a specific day. Staff confirmed that they did not provide the intervention to the resident for an afternoon snack. The nourishment list on the dietary cart did not include the intervention for the resident's afternoon snack. The Food Service Manager stated that the nourishment list was not updated.

The staff's failure to collaborate in updating the nourishment list resulted in the resident not receiving the afternoon snack as per the plan of care. There was low risk to the resident.

Sources: Observations, Resident's written plan of care, nourishment list and interview with staff.

[739633]

WRITTEN NOTIFICATION: RESTORATIVE CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 70 (1)

The licensee has failed to ensure that the home's social work program was coordinated by a designated lead.

Rationale and Summary

The home's Prevention of Abuse and Neglect policy stated that the residents who had been subjected to abuse would be assisted by counselling and other services coordinated by the Resident and Family Relations Coordinator. A resident was subjected to abuse by a visitor. The Administrator acknowledged that the social work service was not provided to the resident after the incident, and the home did not have a designated lead for its social work program.

Sources: The resident's clinical records and progress notes, Home's Prevention of Abuse and Neglect policy and Interview with Administrator.

[739633]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

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

The licensee has failed to ensure that the falls prevention and management program was implemented when assessments were not completed about a resident's condition on all shifts after a fall.

In accordance with O. Reg. 246/22 s 11 (1) (b), the licensee is required to ensure that there are policies developed for the falls prevention and management program, and that they are complied with. Specifically, the staff did not comply with the home's "Fall Prevention and Management Program" as it required staff to complete an assessment of the resident's condition and document it in the progress notes for a minimum of 72 hours following all falls.

Rationale and Summary

(i) A resident had a fall. There was no documentation of the assessment of the resident's condition on one night shift. Resident Care Manager verified that an assessment was not completed and documented on that night shift. Resident Care Manager and Clinical Service Manager, who was the home's fall prevention lead, verified that an assessment of the resident's condition should have been completed and documented on each shift for 72 hours after the resident fell.

There was a risk to the resident when an assessment of the resident's condition was not completed after the fall and when changes in the condition were not monitored.

Sources: The home's Fall Prevention and Management Program, the resident's clinical records, interview with Resident Care Manage and Clinical Service Manager.

[739633]

The licensee has failed to ensure that the falls prevention and management program was implemented when a resident’s diagnostic test was not done during the post-fall assessments for 72 hours.

Rationale and Summary

(ii) Resident Care Manager stated that staff were expected to complete a diagnostic test every time during the 72-hour post-fall assessments if the residents had a specific clinical condition. The Clinical Services Manager acknowledged that the test was not completed in four out of eight assessments completed after the resident's fall, and staff should have done the test every time they completed the post-fall assessment on each shift.

There was a risk to the resident when the diagnostic test was not completed during the post-fall assessments.

Sources: The home's Fall Prevention and Management Program, the resident's clinical records, interview with Resident Care Manager and Clinical Service Manager.

[739633]

The licensee has failed to ensure that the falls prevention and management program was implemented when a resident’s post-fall assessment included review of medication administered within eight hours prior to fall.

In accordance with O. Reg. 246/22 s 11 (1) (b), the licensee is required to ensure that there are policies developed for the falls prevention and management program and that they are complied with. Specifically, staff did not comply with the home's "Fall Prevention and Management Program" as it required staff to review the resident's medication administered within eight hours of falls during the post-fall assessment.

Rationale and Summary

(iii) As per the home’s Fall Prevention and Management Program Policy, staff were required to complete a post-fall assessment according to Appendix 2, which included a review of the resident’s medication administered within eight hours of falls and to check whether the resident was on anticoagulants.

A resident had a fall. The post-fall assessment did not include the review of the resident’s medication administered within eight hours and did not check whether the resident was on anticoagulants.

Clinical Services Manager acknowledged that the post-fall assessment should have included a review of eight hours of medication administration and there was a risk to the resident when the review was not completed during the resident's post-fall assessment.

Sources: The home's Fall Prevention and Management Program, resident's clinical records, interview with Clinical Service Manager.

[739633]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the plan of care interventions for resident's safety during the visits were provided to a resident.

Rationale and Summary

A resident had a reported incident of emotional abuse by a visitor inside their room. The resident's plan of care was reviewed after the incident, and interventions were added for the resident's safety when a particular individual visited the resident. The resident's written plan of care stated that each visit with duration and interventions would be documented, and a skin assessment would be completed after the visits. Resident Care Manager and Administrator confirmed that the visits were not documented, and the skin assessments were not completed after the visits as per the plan of care.

There was a risk to the resident when the plan of care interventions were not provided to the resident.

Sources: The resident's clinical records, progress notes and written plan of care, and interview with Resident Care Manager and the Administrator.

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