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

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| **Report Issue Date:** July 15, 2025 |
| **Inspection Number:** 2025-1437-0003 |
| **Inspection Type:**<br>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): July 8-11, 14, and 15, 2025
The inspection occurred offsite on the following date(s): July 9, 2025

The following intake(s) were inspected:

- Intake: #00146807 - Critical Incident System (CIS) 2954-000021-25 - related to Fall Prevention and Management

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

Resident Care and Support Services
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of Care

NC #001 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.

A resident's care plan indicated that they required fall prevention interventions due to risk for falls.

i) On an identified date, a resident experienced a fall. Video surveillance record showed the fall intervention was not in applied to the resident prior to the fall. A Personal Support Worker (PSW) and Registered Nurse (RN) both acknowledged that the intervention was not implemented at the time of the fall.

**Sources:** Review of a resident's clinical records, Critical Incident System (CIS) report, Video surveillance record, Home's investigation notes, and interviews with a PSW and RN.

ii) The resident was observed with a fall intervention not in place. A PSW acknowledged that the fall prevention interventions were not provided as specified in the resident's plan of care.

**Sources**: Inspector observation, and interview with a PSW .

## COMPLIANCE ORDER CO #001 Duty to Protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse

by anyone and shall ensure that residents are not neglected by the licensee or staff.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall:
(1) Develop and implement a plan to ensure that residents are monitored and that care outlined in each residents' plan of care is provided as specified on an identified shift.
(2) Conduct audits of identified PSWs during the identified shift to ensure care is provided to residents as per their care plans and the residents are monitored as required. Conduct the audits following receipt of this order, for a period of three weeks. Keep a record of the audits, date audit completed, who completed the audit, resident audited, staff member audited, deficiencies identified and how they were corrected.

**Grounds**
The licensee has failed to ensure that residents were not neglected by staff.

Ontario Regulation (O. Reg.) 246/22 s. 7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or pattern of inaction that jeopardizes the health, safety and wellbeing of one or more residents.

On an identified date, the following incidents occurred:

(i) A resident's care plan indicated that they required supervision and close monitoring, and were not to be left unattended or unsupervised. On an identified date, a PSW left the resident at the nursing station unsupervised, after which the resident experienced an adverse event.

(ii) A resident's care plan indicated that they required supervision from staff while ambulating with a specified device. On an identified date, the resident was ambulating in the hallway unsupervised by staff. The two PSWs assigned for the shift were both inside the nursing station and did not attend to the resident at any point for a period of time.

When staff failed to monitor and supervise residents as indicated in their care plans, it jeopardized the residents' health, safety, and well-being.

**Sources:** Review of residents' clinical records, Critical Incident System (CIS) report, Video surveillance record, Home's investigation notes, and interviews with PSWs, Registered Nurse (RN) and other staff.

**This order must be complied with by** September 5, 2025

## COMPLIANCE ORDER CO #002 Transferring and Positioning Techniques

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The Licensee shall

(1) Conduct random weekly audits on an identified shift to observe staff providing the required assistance for transfers to identified residents for a period of three weeks.
(2) Maintain a record of the audits completed, including date, shift time, person completing the audit, observations made, residents' locations at time of observation, care planned transfer directions at time of observation for both residents, and content of on-the-spot education provided and/or other corrective actions taken where required.

**Grounds**
(i) The licensee has failed to ensure that staff used safe transferring techniques for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Fall Prevention and Management Program were complied with.

The home’s Fall Prevention and Management Program Policy indicated that for post fall management, that staff were to use a specific device for post fall transfers.

A resident had a fall. Two staff members manually assisted the resident from the floor without the use of the specified device.

**Sources:** Review of a resident’s clinical records, CIS report , Video surveillance record, Home’s investigation notes, home's policy "Fall Prevention and Management", policy "Staff Zero lift and Transferring Guidelines", and interviews with a PSW, RN, and other staff.

(ii) A PSW independently performed a resident transferred using a device that required the assistance of a second staff member. According to the resident’s care

plan, two staff members were required to perform transfers with the specified device.

**Sources**: Review of a resident's clinical records, Video surveillance record, home's policy "Staff Zero lift and Transferring Guidelines", and interviews with a PSW and other staff.

**This order must be complied with by** September 5, 2025

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Compliance Order CO #002**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**

A CO was issued related to O. Reg 246/22 s. 40 Transferring and Positioning on

September 29, 2023, as part of inspection #2023-1437-0005.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.