Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 12, 2021	2021_777731_0008	002415-21	Complaint

Licensee/Titulaire de permis

The Corporation of the City of St. Thomas
545 Talbot Street St Thomas ON N5P 3V7

Long-Term Care Home/Foyer de soins de longue durée

Valleyview Home
350 Burwell Road St Thomas ON N5P 0A3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KRISTEN MURRAY (731), AYESHA SARATHY (741)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 15, 16, and 17, 2021.

The following Complaint intake was completed within this inspection:

Complaint Log #002415-21 related to allegations of neglect, and personal care.

An IPAC inspection was also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Registered Nurse (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), a Housekeeper, and residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed the home's complaint documentation, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Foot and Nail Care policy included in the required nursing and personal support services program was complied with for three residents.

LTCHA s. 8 (1) (a) requires an organized program of nursing services for the home to meet the assessed needs of the residents.

O. Reg. 79/10 s. 35. (1) requires the long term care home to ensure that each resident in the home receives preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

O. Reg. 79/10 s. 31. (1) (a) Section 35, related to preventative and basic foot care services is included in the organized program of nursing services.

O. Reg. 79/10 s. 30 (1) 1. requires that the program include relevant policies, procedures and protocols.

Specifically, staff did not comply with the home’s policy and procedure “Foot and Nail Care”.

The MLTC received an anonymous complaint regarding alleged neglect of a resident. The home’s policy stated that for residents at risk, foot care was provided by the registered staff (unless otherwise ordered) on a monthly basis after a scheduled bath and documentation was completed in the progress notes. The policy stated that foot care included the health care provider cutting the resident’s toenails.

Three residents were identified as having at risk conditions, and foot care was to be performed by a registered nursing staff. There was no evidence of documentation for foot care in the clinical records for all three residents.

A Registered Practical Nurse (RPN) and Registered Nurse (RN) stated that they completed foot care for residents as needed, and they did not complete any documentation when foot care was completed for residents. The RPN and RN were unaware of the need to complete foot care as required for the three residents, and document in the progress notes, as outlined by the home's policy. The RPN and RN were unable to confirm if the residents were receiving the care as required.

There was minimal risk to the residents that staff were not documenting that foot care had been provided monthly, as outlined in the home's foot and nail care policy.

Sources: The home's "Foot and Nail Care" Policy (#RC&S 08-40); three residents' clinical records, including progress notes and care plans; the LTCH's complaint/response documentation; and interviews with a RPN, an RN and other staff. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for three residents that set out clear directions to staff and others regarding the provision of nail care.

Three residents were identified as having a specific diagnosis in their clinical records.

The bath schedule posted in the tub room of a home area stated in the legend that residents who had the specific diagnosis were to be identified on the bath sheet. The three residents were not identified on the bath schedule with the diagnosis.

A Registered Nurse (RN) and the Director of Care (DOC) acknowledged that the direction for providing foot care on the bath sheet was unclear for staff.

The home's policy stated that for residents at risk, foot care was provided by the registered staff after a scheduled bath, and included cutting the resident's toenails. There was a minimal risk that the three residents could have received inappropriate foot care due to unclear direction to staff.

Sources: The home's "Foot and Nail Care" Policy (#RC&S 08-40); three residents' clinical records, including diagnosis, care plan and paper chart; the home area Bath Schedule; interviews with the DOC and other staff. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint received by the Long Term Care Home concerning the care of a resident was immediately forwarded to the Director.

The home received a written complaint related to allegations of neglect involving care of a resident. The home did not immediately forward the written complaint to the Director. The Director of Care (DOC) confirmed that they did not submit the complaint to the Director. The home's policy stated that a copy of any written complaint received by Valleyview will be sent to the Director, including a description of the follow up actions taken.

Sources: The home's "Advocacy Procedure-Residents/Families" Policy (#1.030); the LTCH's complaint/response documentation; and an interview with the DOC. [s. 22. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the investigation, undertaken related to alleged neglect of a resident, was reported to the Director.

The home received a written complaint related to allegations of neglect involving care of a resident. The home conducted an investigation related to the allegations and did not report the results of the investigation to the Director. The Director of Care (DOC) confirmed that they did not submit the results of their investigation to the Director. The home’s policy stated that every incident of alleged neglect would be fully investigated and the report related to the alleged incident would include a description of the incident, a description of the individuals involved in the incident, actions taken in response to the incident, and the name and title of the person making the report within 10 days of becoming aware of the alleged incident.

Sources: The home’s “Resident Abuse/Neglect – Zero Tolerance” Policy (#RC&S 14-1); the LTCH's complaint/response documentation, including the home’s investigation documentation; and an interview with the DOC. [s. 23. (2)]

Issued on this 3rd day of May, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KRISTEN MURRAY (731), AYESHA SARATHY (741)

Inspection No. / No de l'inspection : 2021_777731_0008

Log No. / No de registre : 002415-21

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Apr 12, 2021

Licensee / Titulaire de permis : The Corporation of the City of St. Thomas
545 Talbot Street, St Thomas, ON, N5P-3V7

LTC Home / Foyer de SLD : Valleyview Home
350 Burwell Road, St Thomas, ON, N5P-0A3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Michael Carroll

To The Corporation of the City of St. Thomas, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) of O. Reg. 79/10.

Specifically, the licensee must:

-Educate all registered nursing staff on the home's foot and nail care policy,
-Document the education, including the date, the staff members who completed the education, and the staff member providing the education,
-Ensure the provision of care, related to foot and toenail care is documented, and
-Implement a monitoring process to ensure that registered staff are completing and documenting foot and toenail care for three residents. The home must maintain a documented record of the monitoring process.

Grounds / Motifs :

1. The licensee has failed to ensure that the Foot and Nail Care policy included in the required nursing and personal support services program was complied with for three residents.

LTCHA s. 8 (1) (a) requires an organized program of nursing services for the home to meet the assessed needs of the residents.

O. Reg. 79/10 s. 35. (1) requires the long term care home to ensure that each resident in the home receives preventative and basic foot care services,

including the cutting of toenails, to ensure comfort and prevent infection.

O. Reg. 79/10 s. 31. (1) (a) Section 35, related to preventative and basic foot care services is included in the organized program of nursing services.

O. Reg. 79/10 s. 30 (1) 1. requires that the program include relevant policies, procedures and protocols.

Specifically, staff did not comply with the home's policy and procedure "Foot and Nail Care".

The MLTC received an anonymous complaint regarding alleged neglect of a resident. The home's policy stated that for residents at risk, foot care was provided by the registered staff (unless otherwise ordered) on a monthly basis after a scheduled bath and documentation was completed in the progress notes. The policy stated that foot care included the health care provider cutting the resident's toenails.

Three residents were identified as having at risk conditions, and foot care was to be performed by a registered nursing staff. There was no evidence of documentation for foot care in the clinical records for all three residents.

A Registered Practical Nurse (RPN) and Registered Nurse (RN) stated that they completed foot care for residents as needed, and they did not complete any documentation when foot care was completed for residents. The RPN and RN were unaware of the need to complete foot care as required for the three residents, and document in the progress notes, as outlined by the home's policy. The RPN and RN were unable to confirm if the residents were receiving the care as required.

There was minimal risk to the residents that staff were not documenting that foot care had been provided monthly, as outlined in the home's foot and nail care policy.

Sources: The home's "Foot and Nail Care" Policy (#RC&S 08-40); three residents' clinical records, including progress notes and care plans; the LTCH's complaint/response documentation; and interviews with a RPN, an RN and other

staff.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents related to the staff not documenting that foot care had been provided as outlined in the home's foot and nail care policy.

Scope: This non-compliance was widespread as the home did not comply with their foot and nail care policy for three out of three residents reviewed.

Compliance History: In the last 36 months, the licensee was found to be in non-compliance with O. Reg. 79/10, s. 8 (1) and one voluntary plan of correction (VPC) was issued to the home. (741)

2.
(731)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2021

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6 (1) of LTCHA, 2007.

Specifically, the licensee must:

-Ensure resident #001's clinical records accurately reflect their current diagnosis,

-Ensure that all bath schedules are updated to identify which residents receive nail care from registered staff.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for three residents that set out clear directions to staff and others regarding the provision of nail care.

Three residents were identified as having a specific diagnosis in their clinical records.

The bath schedule posted in the tub room of a home area stated in the legend that residents who had the specific diagnosis were to be identified on the bath sheet. The three residents were not identified on the bath schedule with the diagnosis.

A Registered Nurse (RN) and the Director of Care (DOC) acknowledged that the direction for providing foot care on the bath sheet was unclear for staff.

The home's policy stated that for residents at risk, foot care was provided by the registered staff after a scheduled bath, and included cutting the resident's toenails. There was a minimal risk that the three residents could have received inappropriate foot care due to unclear direction to staff.

Sources: The home's "Foot and Nail Care" Policy (#RC&S 08-40); three residents' clinical records, including diagnosis, care plan and paper chart; the home area Bath Schedule; interviews with the DOC and other staff.

An order was made by taking the following factors into account:

Severity: There was minimal risk that the residents could have received inappropriate foot care due to unclear direction to staff regarding their diagnosis as identified on the bath sheet.

Scope: This non-compliance was widespread as there was unclear direction to staff for three out of three residents reviewed.

Compliance History: In the last 36 months, the licensee was found to be in non-compliance with LTCHA, 2007, s. 6 (1) and one voluntary plan of correction (VPC) was issued to the home. (741)

2.
(731)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of April, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kristen Murray

Service Area Office / Bureau régional de services : London Service Area Office