Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 16, 2024	
Inspection Number: 2024-1623-0001	
Inspection Type: Complaint	
Licensee: The Corporation of the City of St. Thomas	
Long Term Care Home and City: Valleyview Home, St Thomas	
Lead Inspector Loma Puckerin (705241)	**Inspector Digital Signature**
Additional Inspector(s) Brandy MacEachern (000752)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4, 8, 9, 10, 2024.

The following intake(s) were inspected:

- Intake: #00108303 -Complaint related to resident care and services

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional care and hydration program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration.

The licensee has failed to ensure that the home's policies and procedures related to Nutritional care and hydration were fully implemented for a resident.

Rationale and Summary
A complaint was received by the Director related to the care and services provided to a resident.

During a review of the resident's health records, it was noted that the resident was suffering from a specific condition.

During interviews with the home's staff, they identified that the resident was at risk for the specific condition. A staff acknowledged that the resident should have been assessed and the plan of care updated to reflect the risk for the specific condition.

Policy titled Resident Care and Services, Section: Nutrition and Hydration stated in part that the roles and responsibilities of the RN/RPN were to "collaborate with the interdisciplinary team in the assessment processes on admission, quarterly, with any significant change and at any other time a concern related to nutrition and hydration arises", "implement the plan of care consistently", "complete appropriate documentation as per policy", and "follow up on identified risks and situations and evaluate outcomes".

There was a risk to the resident that the specific condition could have gone unnoticed, and appropriate treatment could not have been provided when the assessments were not started.

Sources: Staff interviews, resident's health records, Policy No. RC&S 12-5.

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WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint.

Rationale and Summary
A compliant related to the care and services provided to a resident was received by the Ministry of Long-Term Care (MLTC).

During an interview with the complainant, they indicated their concerns had not been addressed by the home's management.

A review of the home's complaints log was requested and was not available for review.

During an interview, Director of Care stated the concerns were not documented.

The home's failure to keep a documented record of the complaints received pose a risk of the issues related to residents not being dealt with and resolved in a timely manner.

Sources: Complaint to MLTC, interview with complainant, interview with Director of care.

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