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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 23, 2025
Original Report Issue Date: June 2, 2025
Inspection Number: 2025-1623-0003 (A1)
Inspection Type: Complaint
Licensee: The Corporation of the City of St. Thomas
Long Term Care Home and City: Valleyview Home, St Thomas

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #003 was amended to correct the legislation referred to in the grounds s. 260 (1) from O. Reg 178/24 to O. Reg 246/22. Compliance Order (CO) #004 was amended to correct the legislation referred to in the grounds s. 261 (1) O. Reg 178/24 to O. Reg 246/22 and s. 260 (1) from O. Reg 178/24 to O. Reg 246/22.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15, 16, 20, 22, 23, 26-29, 2025 and June 2, 2025.

The following intake(s) were inspected:

- Intake #00144677 - complaint related to feeding assistance.

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

Food, Nutrition and Hydration
Staffing, Training and Care Standards

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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.

The licensee failed to ensure the plan of care for a resident was provided as per the plan.

The careplan for a resident specified a procedure for staff to complete twice per day at a certain time. In May, 2025, the resident was observed not to have had the procedure completed and this was confirmed during interview with the resident and staff. The staff told the inspector that they were unclear on the timing of the procedure. Registered staff confirmed that the careplan specified the timing of the procedure to be completed and the careplan was not followed. Following this conversation, the timing on the careplan was changed and the procedure was

completed as per the change.

Sources: careplan review, observation, interviews with the resident, staff and registered staff.

Date Remedy Implemented: May, 2025.

COMPLIANCE ORDER CO #001 Nutritional care and hydration programs

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Ensure that the process is followed for making a referral to the registered dietitian (RD) when a resident's diet texture has been downgraded (i.e., from regular to ground, or from ground to puree) by registered staff.
2. Maintain a log of RD follow-ups to the referrals required under condition one including: the resident's name, the date the diet texture was downgraded by

registered staff, the date the RD followed up, the outcome of the follow-up, and the RD's signature.

3. Complete a review of the home's menu cycle to ensure all ground texture menu items meet the the food particle size requirements outlined in the home's diet texture policy. Maintain a log of any ground texture foods which were identified that did not meet the food particle size requirements outlined in the home's diet texture policy. Include the food/menu item name, the meal when the food was planned to be served (e.g., week one, Wednesday, lunch), the date when the issue was identified, who identified the issue, and any corrective actions taken to fix the issue.

4. Develop a written process to ensure that any current and future ground texture foods are being checked by staff of the home to ensure that the size of any food particle meets the requirements in the home's diet texture policy.

5. Provide training on the process under condition four to anyone who may be responsible for implementing the process. Maintain a log of this training including: the name of the person receiving the training, the date the training occurred, and a signature of the trainee indicating that they understand the process.

Grounds

A) The licensee has failed to ensure that the program for nutritional care and hydration included the implementation of policies and procedures related to nutritional care and dietary services when a resident was not assessed by the Registered Dietitian (RD) after their diet texture had been downgraded by the registered staff.

Rationale and Summary

In May 2025, a resident was documented as having a choking episode requiring intervention by staff. A Registered Nurse (RN) documented that they had downgraded the resident's diet texture and notified the kitchen staff on the same day. As per the homes policy, downgrades in diet texture could be done registered staff with the RD to assess on their next visit. The RD visited the home multiple days in May before they completed an assessment on the resident.

Sources: progress notes, the homes "Dietary - Nutritional Care Policy", diet orders, assessments, and interviews with the RD and scheduler.

B) The licensee has failed to ensure that policies and procedures related to dietary services were implemented in consultation with a registered dietitian (RD) who is a member of the staff of the home, when a dessert was served to residents which did not meet the requirements of the ground texture diet.

Rationale and Summary

During a dining observation by an Inspector in May 2025, a resident had a severe choking incident.

Per the Nutritional Management Services policy, "Diet Types and Textures RD Review" , the ground texture diet meant that all ground particles were less than 6 millimeters (mm) in size and would be served in a cohesive form. Any foods that could not be sufficiently ground would be served in pureed form. The production sheet for the dessert offered at the meal, stated that the product was suitable for ground texture diets.

During the inspection, a sample piece of the dessert, the same type which had been served to the resident was obtained from the Acting Food Services Supervisor. Inspectors measured the size of several raisins to be 10-25mm in length. These findings were shown to the RD, Acting Food Services Supervisor, and Nutritional

Management Services Regional Manager, who each confirmed that this food product would not meet the definition of ground texture in their policy, and that this would pose a risk to resident safety for residents on this diet texture. The home did not have an implemented procedure to ensure the food items on the ground menu met the diet specifications.

Sources: progress notes, production sheet for carrot cake, Diet Types and Textures RD Review policy (Dated: Jan 14, 2025), observations, and interviews with the RD, an RN, an RPN, Acting Food Service Supervisor, and Nutritional Management Services Regional Manager.

This order must be complied with by June 30, 2025.

COMPLIANCE ORDER CO #002 Training

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.

10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

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

1. Ensure that 21 specific are provided orientation training pursuant to sub-section 82 (2) of the FLTCA, 2021.
2. Keep a record of the training, including the staff names, and date(s) the training was completed.
3. Develop and implement a process to ensure that any staff hired pursuant to a contract after this licensee report has been issued, complete the required orientation training pursuant to sub-section 82 (2) of the FLTCA, 2021.

Grounds

The licensee has failed to ensure that all staff hired pursuant to a contract received orientation training before performing their responsibilities in the home.

The definition of "staff", in relation to a long-term care home, means persons who work at the home,

(a) as employees of the licensee,

(b) pursuant to a contract or agreement with the licensee, or

(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

Rationale and Summary

During an interview with a staff member, they stated that they had not received orientation training for Valleyview Home. The home's Training and Orientation Lead, stated that orientation training was provided via Surge Learning, and that they facilitated this training for staff who were employed directly by the home. The ADOC stated that staff who were contracted through two different companies did not have access to Surge Learning and was unsure if those staff had received orientation training. The ADOC also stated that another staff member also did not receive their orientation training.

During an interview the Administrator stated that they believed the contracted companies would have completed the required orientation training with their staff. The Director of Care, DOC also confirmed that the contracted staff had not been set up in Surge Learning to do the orientation training. Based on review of the staff lists, the home did not provide orientation training to 10/38 contracted staff who had all been hired within the past year.

Sources: interviews with Acting Food Services Supervisor, a company Regional Manager, ADOC, Environmental Services Manager, a company Operations Supervisor, the DOC, and the Administrator, and record reviews of the staff lists for contracted companies.

This order must be complied with by July 11, 2025.

COMPLIANCE ORDER CO #003 Training

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 82 (4)

Training

s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

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

The licensee shall:

1. Ensure that 23 specific staff who have received training under s. 82 (2) receive retraining in the areas mentioned in that subsection.
2. Keep a record of the training including the staff names and date(s) the training was completed.
3. Develop and implement a process to ensure that any staff hired pursuant to a contract after this licensee report has been issued, complete the required annual retraining pursuant to sub-section 82 (4) of the FLTCA, 2021

Grounds

The licensee has failed to ensure that the persons who have received training under subsection (2) have received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

s. 260 (1) O. Reg. 246/22 states: The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

s. 82 (2) specifies that every licensee shall ensure that all staff at the home performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.

2. The long-term care home's mission statement.

3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

4. The duty under section 28 to make mandatory reports.

5. The protections afforded by section 30.

6. The long-term care home's policy to minimize the restraining of residents.

7. Fire prevention and safety.

8. Emergency and evacuation procedures.

9. Infection prevention and control.

10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

11. Any other areas provided for in the regulations.

The definition of "staff", in relation to a long-term care home, means persons who work at the home,

(a) as employees of the licensee,

(b) pursuant to a contract or agreement with the licensee, or

(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

Rationale and Summary

Interviews with the Administrator, DOC, Training/orientation lead/ADOC confirmed that the contract staff of the home were not set up with Surge Learning to complete mandatory retraining.

Interviews with the five specific staff confirmed that they did not receive mandatory retraining.

The company Regional Manager and Acting Food Services Manager confirmed that their contracted dietary staff staff did not receive mandatory retraining.

The company Operations Supervisor confirmed that their contracted cleaning staff did not receive mandatory retraining.

Discussion with the company Clinical Coordinator confirmed that the Dentist and Dental Assistant did not receive mandatory retraining.

Based on review of staff lists, 18/27 staff as well as all other contract staff did not complete retraining on the areas required to be completed for staff for 2024/25.

Sources: interviews with the Administrator, DOC, Training/orientation lead/ADOC, five contract staff, a company Regional Manager and Acting Food Services Manager (FSM) and a company Operations Supervisor; email discussion with a company Clinical Coordinator; record review of staff listing for the companies contract services.

This order must be complied with by July 11, 2025.

COMPLIANCE ORDER CO #004 Training

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 82 (7)

Training

s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.

2. Mental health issues, including caring for persons with dementia.

3. Behaviour management.

4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

5. Palliative care.

6. Any other areas provided for in the regulations.

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

The licensee shall:

1. Develop a definition of 'direct care' to be used as part of the Training and Orientation Program to assess the training needs of staff positions within the home.

2. Ensure that 7 specific staff and any other staff who meet the home's definition of providing direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out pursuant to s. 82. (7).

3. Keep a record of the training including the staff names and date(s) the training was completed.

Grounds

The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations.

s. 261 (1) O. Reg. 246/22 states: For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.

2. Skin and wound care.

3. Continence care and bowel management.

4. Pain management, including pain recognition of specific and non-specific signs of pain.

5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

s. 260 (1) O. Reg. 246/22 states: The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The definition of "staff", in relation to a long-term care home, means persons who work at the home,

(a) as employees of the licensee,

(b) pursuant to a contract or agreement with the licensee, or

(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel").

Rationale and Summary

Interviews with the Administrator, DOC, Training/orientation lead/ADOC confirmed that the contract direct care staff of the home were not set up with Surge Learning to complete mandatory retraining for 2024/25.

Interviews with five direct care contract staff confirmed that they did not receive mandatory direct care staff retraining.

Discussion with the company Clinical Coordinator confirmed that the Dentist and Dental Assistant did not receive mandatory direct care staff retraining.

Sources: interviews with the Administrator, DOC, Training/orientation lead/ADOC, five contract direct care staff and email discussion with the company Clinical Coordinator.

This order must be complied with by July 11, 2025.

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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

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
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
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.