Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2018	2018_725522_0014	021057-18	Critical Incident System

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

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 4 and 5, 2018.

This Critical Incident System (CIS) inspection was related to a resident incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Assistant Director of Nursing, a Registered Nurse, Personal Support Workers and a family member.

During the course of the inspection, the inspector(s) also completed a clinical record review.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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	Legendé 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date. The CIS indicated that an identified resident had an incident the day prior.

In an interview, the Assistant Director of Nursing (ADON) confirmed that they were responsible for submitting CIS reports to the MOHLTC. The ADON stated that they were informed of the incident when it occurred, and came into the home. The ADON stated they had attempted to call the MOHLTC after hours line, but had called the wrong number. The ADON stated after management discussion the next morning it was determined that a CIS report should be submitted. The ADON stated they submitted the CIS report to the MOHLTC the day after the incident occurred.

In an interview, the Director of Nursing acknowledged the CIS reported related to the incident involving the identified resident should have been submitted to the MOHLTC immediately.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide. [s. 107. (1) 2.]

Issued on this 17th day of October, 2018

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

Original report signed by the inspector.