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 prévue 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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 12, 2019	2019_607523_0042 (A1) (Appeal\Dir#: DR# 128)	016441-19, 016668-19, 016763-19, 016872-19	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

Amended by Pamela Chou (Director) - (A1)(Appeal\Dir#: DR# 128)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on November 12, 2019.
Order(s) CO#001 was/were rescinded to reflect the Director's review DR# 128.

Issued on this 12nd day of November, 2019 (A1)(Appeal\Dir#: DR# 128)

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

Original report signed by the inspector.

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

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

Amended by Pamela Chou (Director) - (A1)(Appeal/Dir# DR# 128)

Amended 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): September 10 and 11, 2019.

This inspection was conducted with inspector #610.

This inspection was conducted for the following Critical Incidents:

Intake Log #016763-19, CIS #M628-000031-19 related to allegations of staff to resident abuse.

Intake Log #016441-19, CIS #M628-000028-19 related to allegations of staff to resident abuse

Intake Log #016668-19, CIS #M628-000030-19 related to allegations of staff to resident abuse.

Intake Log #016872-19, CIS #M628-000032-19 related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care, Dietary Services Manager (DSM), Continuous Quality Improvement (CQI) Coordinator, Dietary Aide, two Registered staff members, eight Personal Support Workers and two residents.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed specific policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.

3 WN(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

A) The home submitted a Critical Incident System (CIS) report on a certain date to the Ministry of Long-Term Care related to allegations of staff to resident abuse.

The CIS indicated that a staff member witnessed other staff physically abusing a resident by placing a washcloth in the resident's mouth, covering their mouth with their hand, slapping the resident and addressing them using profane words.

In an interview a specific PSW said that they witnessed another PSW put a cloth in the resident’s mouth and told them to shut up, they also saw the PSW taking the cloth out from the resident’s mouth and covering their face aggressively and told them to shut up.

Interview with specific PSW and review of specific text message from staff showed that when the resident was yelling or screaming they would put their hands over the resident's mouth and give them direction to stop.

In an interview the DOC said they were aware that when the resident was yelling or screaming the staff have put their hands on the resident mouth to hold the mouth closed tightly for them to quite and stop yelling. DOC said that this was not part of the resident’s plan of care.

The DOC said that staff would roll a wash cloth and give it to the resident as a distraction, the resident would put the wash cloth in their mouth and continue to growl and carry on like an animal and usually they will spit it or throw it away. DOC said that this was not part of the resident’s plan of care.

B) The home submitted a CIS to the Ministry of Long-Term Care related to allegations of staff to resident abuse.

The CIS indicated that a visitor witnessed a PSW was scolding and chastising the resident for pulling their pants down. The PSW changed their tone when they saw the visitor.

A review of the internal investigation notes showed that the PSW was founded to have verbally abused the resident and the PSW was terminated.

In an interview the DOC said that the staff member admitted to the incident but they said it was not their intent to verbally abuse the resident.
The DOC said that given the information they had they terminated the PSW based on staff to resident verbal abuse.

C) The home submitted a CIS to the Ministry of Long-Term Care related to allegations of staff to resident abuse.

The CIS indicated that on a certain date a visitor heard and observed a specific staff member telling a specific resident in a loud voice "get, get, move along". Visitor observed the staff member using hand gestures to shoo the resident along. The visitor informed the RPN about their concerns.

A review of the internal Investigation notes showed that the home concluded that the staff member can be loud in their voice and mannerism but the allegations were inconclusive, counseling was provided.

In an interview Dietary Service Manager (DSM) said that the staff member was concerned about the safety of the resident and concerned that they were going to touch the hot food cart. We provided counseling to the staff member to use softer tone and different approach, so she was not perceived verbally abusing resident.

The licensee has failed to ensure that specific residents were protected from staff to resident abuse.

During this inspection, this non-compliance was found to have a severity of level 2 as there was a minimal discomfort or minimal risk of harm to the resident. The scope of this non-compliance was a level 3 as it was widespread. The home had no previous noncompliance in this area. [s. 19. (1)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 128)
The following order(s) have been rescinded: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A review of three Critical Incident System (CIS) reports submitted to the Ministry of Long-Term Care related to allegations of staff to resident abuse showed that the staff were made aware of allegations of staff to resident abuse and the staff did not report the alleged abuse immediately.

In an interview the DOC said they noted that the staff were not immediately reporting allegations of abuse. We had meetings with the registered staff and hoping this would be rectified.

During this inspection, this non-compliance was found to have a severity of level 2 as there was a minimal discomfort or minimal risk of harm to the resident. The scope of this non-compliance was a level 3 as it was widespread. This non-compliance was previously issued as:
A Written Notification, Voluntary Plan of Correction on May 7, 2018, under inspection # 2018_725522_000. [s. 24. (1) 2.]

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 O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The Criminal Code defined assault in section 265 (1) (a) A person commits an assault when without the consent of another person, he applies force intentionally to that other person, directly or indirectly.
The Criminal Code defined assault in section 265 (1) (b) A person commits an assault when (b) he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe on reasonable grounds that he has, present ability to effect his purpose.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care related to allegations of staff to resident abuse.

The CIS indicated that a staff member witnessed other staff physically abusing a resident.

The CIS showed that the appropriate police force was not notified of the alleged incident of staff to resident physical abuse.

In an interview the DOC said that they have not reported this incident or any other staff members to the police for any other offences of staff to resident abuse. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

Issued on this 12nd day of November, 2019 (A1)(Appeal/Dir# DR# 128)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
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 Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Pamela Chou (Director) - (A1) (Appeal/Dir# DR# 128)
Inspection No. / No de l'inspection :	2019_607523_0042 (A1)(Appeal/Dir# DR# 128)
Appeal/Dir# / Appel/Dir#:	DR# 128 (A1)
Log No. / No de registre :	016441-19, 016668-19, 016763-19, 016872-19 (A1) (Appeal/Dir# DR# 128)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 12, 2019(A1)(Appeal/Dir# DR# 128)
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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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:

(A1)(Appeal/Dir# DR# 128)
The following Order(s) have been rescinded:

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

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order # / Ordre no : 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. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24 of the LTCHA.

Specifically, the licensee must:
a) Ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

b) Ensure that all staff of the home including the management team receive training on the home's policy and procedures for prevention of abuse and neglect and the duty of reporting to the Director and appropriate police service. A record of this education will be kept.

Grounds / Motifs :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A review of three Critical Incident System (CIS) reports submitted to the Ministry of Long-Term Care related to allegations of staff to resident abuse showed that the staff were made aware of allegations of staff to resident abuse and the staff did not report the alleged abuse immediately.

In an interview the DOC said they noted that the staff were not immediately reporting allegations of abuse. We had meetings with the registered staff and hoping this would be rectified.

During this inspection, this non-compliance was found to have a severity of level 2 as there was a minimal discomfort or minimal risk of harm to the resident. The scope of this non-compliance was a level 3 as it was widespread. This non-compliance was previously issued as:
A Written Notification, Voluntary Plan of Correction on May 7, 2018, under inspection # 2018_725522_000. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

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 Health and 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 Health and 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 de la Santé et 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 de la Santé et 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 12nd day of November, 2019 (A1)(Appeal/Dir# DR# 128)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by Pamela Chou (Director) - (A1) (Appeal/Dir# DR# 128)

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