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**
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# Original Public Report

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| **Report Issue Date:** February 24, 2023 | |
| **Inspection Number:** 2023-1623-0001 | |
| **Inspection Type:**<br>Critical Incident System | |
| **Licensee:** The Corporation of the City of St. Thomas | |
| **Long Term Care Home and City:** Valleyview Home, St Thomas | |
| **Lead Inspector**<br>Peter Hannaberg (721821) | **Inspector Digital Signature**<br>Peter Benjamin Hannaberg<br>Digitally signed by Peter Benjamin Hannaberg<br>Date: 2023.02.24 16:09:57 -05'00' |
| **Additional Inspector(s)**<br>Terri Daly (115) | |

## INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 14, 15, 16, 21, and 22, 2023

The following intake(s) were inspected:

- Intake #00005127 for Critical Incident M628-000018-22 - Related to an altercation and responsive behaviours between two residents.
- Intake #00006590 for Critical Incident M628-000006-22 - Related to an unexpected death of a resident.
- Intake #00017866 for Critical Incident M628-000001-23 - Related to alleged neglect of care of multiple residents.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

# 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)**
O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that they implemented, any standard or protocol issued by the Director with respect to infection prevention and control.

**Rationale and Summary**
IPAC Standard 10.1 stated, "The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR."
Public Health Ontario Fact Sheet Titled, Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes stated "do not use expired product. Be sure to note product expiration date when selecting product."

During the initial tour of the home on February 14, 2023, over half of the ABHR wall mount dispensers were observed on all five home and resident areas with expiry dates from 2022.

During an interview with the Environmental Supervisor they stated that this must have been an oversight by staff. Since becoming aware they had rotated stock so that the more current dates for expiry are used prior to the 2024 stock. A staff member had been assigned and all expired ABHR had been replaced.

On February 16, 2023, an observation was completed of ABHR and all expired product had been replaced.

**Sources**
Observations and interview with the Environmental Supervisor.

Date Remedy Implemented: February 16, 2023. [115]

## WRITTEN NOTIFICATION: Residents' Bill of Rights

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 3 (1) 3.

The licensee has failed to ensure that a resident's rights were fully respected when staff were uncertain of the resident's decision to not be resuscitated.

**Rationale and Summary**
In February 2022, a resident was found in their bed with vital signs absent. The resident/resident's substitute decision-maker (SDM) had not yet completed the Treatment Plan for CPR, however a progress note from February 2022 indicated that the resident wanted CPR.

During an interview with the Director of Care, they indicated that if a resident or their SDM has not yet decided on the Treatment Plan for CPR then they automatically are to receive CPR if found with vital signs absent.

During an interview with two registered staff, both stated that the chart had a red heart sticker on the spine of the binder, indicating that this resident was to receive CPR. Both indicated that CPR was not initiated until the on-call physician was called.

A review of the resident's clinical records showed that the resident/resident's SDM had not signed the Treatment Plan for CPR at that time, as they wanted to take some time to think about it. Therefore, at the time of the resident's death the directive would have been to initiate CPR immediately, therefore the licensee did not respect the resident's wishes by not initiating CPR until after the physician was called.

**Sources**
Critical Incident #M628-000006-22, resident clinical record – progress notes, interviews with staff. [115]