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

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Original Public Report

Report Issue Date: November 7, 2024
Inspection Number: 2024-1623-0004
Inspection Type: Complaint Critical Incident
Licensee: The Corporation of the City of St. Thomas
Long Term Care Home and City: Valleyview Home, St Thomas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 4, 5, 2024.

The following intake(s) were inspected:

- Intake: #00123316 - Complaint related to resident care concerns; and
- Intake: #00124728 - Critical Incident System (CIS) report #M628-000020-24, related to alleged resident abuse.

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

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that an alleged incident of resident abuse, that the licensee knew of was immediately investigated.

Rationale and summary:
A review of the home's investigation notes supported the licensee was aware of an alleged incident of resident abuse, and did not immediately start their investigation.

The Director of Care (DOC) said they did not immediately investigate and should have.
When the licensee failed to immediately investigate this impacted the resident's right to live in a safe and secure home and increased their risk of harm.

Sources: CIS report, the home's investigation notes and interviews with management.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)

Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee has failed to ensure that all appropriate actions were taken in response to an alleged incident of resident abuse.

Rationale and summary:
A review of the home's investigation notes supported the licensee was aware of an alleged incident of resident abuse, and did not provide the information to the home's investigator right away. Furthermore, the home's investigation notes did not include a documented record of the licensee's interview with the resident, did not include any interviews with the staff members who allegedly reported the allegations and did not include an interview with charge nurse who reported the allegations to the DOC.

Additionally, a review of the resident's clinical records showed there were no documented progress notes, or any resident assessments of any kind to support the licensee responded and then acted appropriately to ensure the resident's safety.

When the licensee failed to ensure that all actions were taken to respond and act appropriately when investigating the allegations involving the resident, they impacted the resident's right to reside in a safe and secure home and increased their risk of harm.

Sources: CIS report, resident clinical record review, home's investigation notes and interviews with management.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director

s. 28 (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:
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.

The licensee has failed to ensure that when a person who had reasonable grounds to suspect the abuse of a resident by staff that resulted in a risk of harm, the suspicion and the information upon which it was based was immediately reported to the Director.

Rationale and summary:
A review of the home's investigation notes supported the Registered Nurse (RN), who was acting RN supervisor, was aware of the allegations of resident abuse, and reported the allegations to the DOC.

As per the home's Resident Abuse and Neglect policy, after hours, and on weekends and holidays the RN supervisor will notify the MOLTC after hours pager of the incident and record the incident number in the progress notes.

A review of the CIS report documented the report was not submitted immediately when the licensee became aware of the allegations.

The DOC said they were aware of the allegations, did not submit the CIS report immediately and should have. Furthermore, it was the DOC's expectation that registered staff member should have immediately reported the allegations.
When the licensee failed to immediately report the allegations it impacted the resident's right to live in a safe and secure home and increased the resident's risk of harm.

Sources: CIS report, home's investigation notes, interviews with staff and management.