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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: September 11, 2025
Inspection Number: 2025-1353-0006
Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Valley East Long Term Care Centre Inc.
Long Term Care Home and City: Elizabeth Centre, Val Caron

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 3-5, and 8-11, 2025.

The following intakes were inspected:
- One follow-up intake related to policy to promote zero tolerance.
- One follow-up intake related to required programs.
- One follow-up intake related to transferring and positioning techniques.
- One follow-up intake related to falls prevention and management.
- One intake related to the improper/incompetent care of a resident.
- One intake related to a medication incident.
- One intake and complaint related to concerns of physical abuse of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1353-0003 related to FLTCA, 2021, s. 25 (1)
Order #003 from Inspection #2025-1353-0003 related to O. Reg. 246/22, s. 53 (1) 3.
Order #002 from Inspection #2025-1353-0003 related to O. Reg. 246/22, s. 40
Order #001 from Inspection #2025-1353-0005 related to O. Reg. 246/22, s. 54 (2)

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

Resident Care and Support Services

Continence Care
Medication Management
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provide direct care to residents are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, related to the use of a medication.

A resident was provided with a medication when the consent had been withdrawn on two previous occasions.

Sources: Resident electronic health files; internal investigation notes; interviews with staff.

WRITTEN NOTIFICATION: Protection from restraining and confining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.

The licensee has failed to ensure that a resident was not restrained for the convenience of the staff.

A resident was found restrained in a way for the convenience of staff.

Sources: A resident's electronic health files; internal investigation notes; Interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that a resident received the correct dose of medication as ordered.

A resident received an incorrect dose of medication due to a breakdown in communication.

Sources: A resident’s electronic health files; internal investigation notes; interviews with staff.

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