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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 6, 2014	2014_395151_0004	000323,000324-14	Follow up

Licensee/Titulaire de permis

VALLEY EAST LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

Long-Term Care Home/Foyer de soins de longue durée

ELIZABETH CENTRE
2100 Main Street, Val Caron, ON, P3N-1S7

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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 14,15,16,17, 2014

This inspection relates to follow-up of orders previously issued to the home:
S-000323-14 relating to order issued in report: 2014-140158-0004
S-000324-14 relating to order issued in report: 2014-140158-0004

During the course of the inspection, the inspector(s) spoke with
- Administrator
- Acting Director of Care
- Staff Educator
- Restorative Care Coordinator
- Food Service Supervisor
- Dietary Care Aides
- Registered Staff
- Personal Care Workers (PSW)
- Residents
- Family Members

During the course of the inspection, the inspector(s)
- made direct observations of care and service delivery to residents
- reviewed resident health care records
- reviewed the home's policy on zero tolerance for abuse
- walk-through of the home several times daily
- reviewed the home's educational records in reference to staff education for policy of zero tolerance for abuse and staff response to the resident who is choking,
- reviewed the home's policies, procedures, protocols and programs in regards to the management of resident responsive behaviours
- reviewed staff personnel records
- observed meal service delivery to residents

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. Inspector 151 observed a locked medication cart in the corridor outside of the dining room. On the cart table was a small plastic cup 1/4 full of a white powder. No label identified what the content of the cup was and for whom it was intended. No registered staff had direct view of the cart. Inspector located Staff #203 in the dining room. Staff #203 confirmed the following: the white powder was a protein supplement, the medication was pre-poured at the onset of the medication pass, the amount was specific to a resident and the direction was that the medication was to be added to the resident's food at breakfast. Staff #203 confirmed that the home's policy is not to pre-pour medications. Staff #203 stated the policy directs staff to pour the medication, immediately administer the medication to the resident and then to sign for the administration of the medication in the Medication Administration Record for that resident. Staff #203 then retrieved the cup from the cart and proceeded to the dining room stating she would now be giving the medication to the resident.

The licensee did not provide for an inter-disciplinary medication management system that provided safe medication management and optimized effective drug therapy outcomes for residents [s. 114. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. During breakfast meal on Home Area 1, Inspector observed the medication cart to be in the hallway, unlocked and not in direct line of observation of any staff person. Inspector was able to open drawers and inspect the contents without being noticed. Inspector stayed with the cart until Staff #211 returned. Staff #203 stated that the cart was only left unsupervised for a few minutes while staff #211 administered a pain medication to a resident in the dining room.

The licensee did not ensure that steps were taken to ensure the security of the drug supply as areas where drugs were stored were not kept locked at all times, when not in use. [s. 130. 1.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_332575_0010	151
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2014_332575_0010	151

Issued on this 6th day of November, 2014

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