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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 14, 2016	2015_283544_0030	004379-15	Complaint

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

FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 1, 2, 3, 2015 related to a resident exhibiting aggressive responsive behaviours.

Inspector reviewed three complaint logs.

During the course of the inspection, the inspector(s) spoke with Administrator, Co-Director of Care (Co-DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents and Families.

Inspector also toured the home, observed staff to resident interactions, resident care and services provided, the management of residents exhibiting responsive behaviours, reviewed residents' health care records, residents' care plans and the home's policies and procedures pertinent to this inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care, set out in the plan of care, was provided to resident # 003 as specified in the plan.

Inspector reviewed three complaint logs that were submitted regarding a resident's responsive behaviours.

According to the complaints, resident # 003 exhibited responsive behaviours since their admission to the home including wandering into other residents' rooms, frightening other residents, verbal responsive behaviours directed at staff and other residents and physical responsive behaviours directed at staff and other residents.

Inspector reviewed resident # 003's care plan and identified that resident # 003 required cueing/assistance to go to the bathroom at specific hours during the day. The staff of the home was required to monitor resident # 003 hourly and document a summary of each responsive behaviour episode noting the causes and successful interventions. The care plan also identified that Dementia Observation System (DOS) documentation was to be initiated and was to be ongoing whenever resident # 003 exhibited these responsive behaviours.

Inspector reviewed the Behavioural Support Ontario assessment that was conducted for resident # 003. Assisting resident # 003 with their toileting program was identified as a priority.

Inspector reviewed resident # 003's health care record and identified that there was no documentation to support that resident # 003 was being cued or assisted to the bathroom as identified in their care plan. The documentation regarding resident # 003's responsive behaviours was incomplete and often did not address the causative factors or the successful interventions. Further, although resident # 003 exhibited multiple episodes of responsive behaviours, there were only two episodes of DOS documentation. The inspector identified that during both of these periods, the DOS documentation was incomplete.

Inspector interviewed PSW # 106, RN # 107 and RPN # 108 who all told the inspector there was no documentation to support that resident # 003 was cued or taken to the bathroom at the times specified in the care plan. The above staff told the inspector that under the task bar in Point Click Care (PCC), the staff were to document when this task was completed by using a check mark. The clock under this task was in the "off" position which meant that the staff were not alerted to completing this task, therefore, this task was not checked off nor completed for resident # 003. They all told the inspector that DOS documentation, once initiated, was to be conducted for several days.

The Co-DOC told the inspector that DOS documentation was required whenever a resident exhibited responsive behaviours and confirmed that the progress notes, written by her, identified that the DOS documentation was incomplete.

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 care, set out in the plan of care, is provided to resident # 003 as specified in the plan, to be implemented voluntarily.

Issued on this 14th day of January, 2016

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

Original report signed by the inspector.