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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 19, 2016	2015_283544_0031	004825-15	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): December 1, 2, 3, 2015.

Seven Critical Incidents reports were reviewed: four related to allegations of staff to resident abuse, two related to resident's falls and one related to a disease outbreak.

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

The inspector also reviewed resident health care records, resident care plans, internal incident investigation reports, the home's policies and procedure's regarding Falls Prevention and Prevention of Abuse/Neglect, staff training logs and components of employee human resource files, observed staff to resident interactions and staff providing care and services to the residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector reviewed two Critical Incident reports in relation to resident # 001 and resident # 002, who both had a fall in the home that resulted in injuries and transfer to hospital.

Inspector reviewed the home's Fall Prevention Policy titled, "Resident Rights, Care Services- Required Programs- Falls Effective Date: September 16, 2013 Revised Date: October 21, 2015.

The policy stated that, " each resident, who has a fall, will have a completed falls incident progress note, which reflects circumstances of the fall, an assessment of the resident, as well as additional interventions to be implemented to prevent further falls or injury. A fall progress note is to be completed for at least three shifts following the incident."

The policy also stated that, " a reassessment post fall and where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls".

In an interview with S # 101, the inspector was told that the home did not have a post fall assessment instrument specifically designed for falls. There was one in Point Click Care but it was retired in 2013.

In an interview with S # 101 RN # 110, RPN # 108 and S # 111, it was confirmed that when a resident has had a fall, the resident's vital signs are to be taken, they are to be quickly examined for any injuries by the registered staff and are to be placed back into their beds via mechanical lift. If the resident's injuries appear to be more severe, an ambulance would be called and the resident sent to the hospital for evaluation. A fall incident note is to be completed in Point Click Care. A referral note to the Physiotherapy department is to be sent.

In an interview with a member of the multidisciplinary team, it was confirmed that the team member, upon receiving a referral, will conduct a three stage assessment within seven days of the the resident falling. The tests included are for balance, range of motion and strengthening. The team member documents their assessment in Point click Care under "Fall Follow-up note". The team member confirmed that they do not conduct a post

fall assessment.

The progress notes were reviewed by the inspector with S # 111 who confirmed that the initial incident progress notes of the falls, were incomplete for resident # 001 and resident # 002. RPN # 106 and RN # 110 also confirmed that the falls incident notes were incomplete for resident # 001 and resident # 002 and that the progress notes did not include documentation for three shifts as per the home's policy.

S # 101 confirmed that a fall progress note for three shifts was not completed for resident # 001 and resident # 002. The only documentation found was at the time the fall occurred. [s. 8. (1) (a),s. 8. (1) (b)]

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 Falls Prevention policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

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

Inspector reviewed Critical Incident report related to an allegation of resident abuse by a staff member.

According to the report, the incident was not reported immediately to the Director.

This was confirmed by the Administrator and S # 101.

2. Inspector reviewed a second Critical Incident report related to an allegation of abuse of a resident by a staff member.

According to the report, the incident was not reported to the Director immediately.

This was confirmed by the Administrator and S # 101.

3. Inspector reviewed a third Critical Incident report related to an allegation of abuse of a resident by a staff member.

According to the report, the incident was not reported immediately to the Director.

This was confirmed by the Administrator and S # 101. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, that the resident was assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Inspector reviewed a Critical Incident related to resident # 001 who had a fall that resulted in a transfer to hospital and sustained an injury.

Inspector reviewed resident # 001's health care records, progress notes and assessments. In 2014, resident had numerous falls documented in their health care record and more falls in 2015. The review of resident # 001's health care record also identified that there was no documentation that identified a post fall assessment was conducted using a clinically appropriate assessment instrument after the fall whereby, resident # 001 sustained an injury. The progress notes, related to the fall, were found to be incomplete.

Inspector interviewed a member of the multidisciplinary team who confirmed that when a resident has fallen, the team member should receive a referral and the resident is to be assessed within seven days of the fall. The team member does not conduct a post fall assessment. They are to document a post fall note, dated on the day of their assessment, in Point Click Care (PCC) under the tab, "Post Fall Note". A post fall note should include documentation of tests that are conducted in three areas, the resident's mobility, range of motion and strengthening capacity to assess if the resident was still able to engage in physiotherapy activities or required a referral to restorative care.

An interview with the inspector and RPN # 112, RN # 110, RPN # 108, and RN # 106 confirmed that when a resident has had a fall, their vital signs are to be taken, they are to be quickly assessed for any injuries and are to be placed back into their bed via mechanical lift. If their injuries appear to be more severe, an ambulance would be called and the resident sent to the hospital for an evaluation. A fall incident note is to be completed in Point Click Care. They confirmed that they were unaware that a post fall assessment, using a clinically appropriate assessment instrument, was to be conducted. They were not aware of an instrument that was to be used. The above staff members reviewed the Assessment tab in Point Click Care (PCC), with the inspector, and identified that the Post Fall Assessment identifier, from the drop down screen, had been retired in 2013. [s. 49. (2)]

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 when a resident has had a fall, the resident is assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity, was fully respected and promoted.

Inspector reviewed a Critical Incident report related to alleged staff to resident physical abuse.

Inspector reviewed resident # 006's health care record and progress notes. According to the report and resident # 006's health care record, resident # 006 was being transferred from their bed to their wheelchair. During the transfer, PSW # 104 grabbed a part of resident # 006's body to turn and direct the resident into the chair. While resident # 006 was in the mechanical lift, resident # 006 began to yell, "don't touch me, don't touch me". PSW # 104 continued transferring resident # 006.

Inspector interviewed the S # 101 who stated that PSW #104 was immediately placed off work when S # 101 was notified of the incident. After an investigation was completed by the home, PSW # 104 was disciplined and their actions were found to be unprofessional.

Inspector interviewed resident # 006 who stated that PSW # 104 did not stop when they yelled out to stop as requested. Instead PSW started to laugh. This was when resident # 006 called out in pain and asked PSW to stop and not touch them. Resident # 006 told the inspector they felt it was a violation of their rights. [s. 3. (1) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident.

Inspector reviewed a Critical Incident related to alleged staff to resident abuse.

According to the report, resident # 006 was being transferred from their bed to their wheelchair. During the transfer, PSW # 104 grabbed a part of resident # 006's body to turn and direct the resident into the chair. While resident # 006 was in the mechanical lift, resident # 006 began to yell, "don't touch me, don't touch me". PSW # 104 continued transferring resident # 006.

Inspector reviewed resident # 006's progress notes and identified that resident # 006 sustained some injuries. Resident # 006 told the staff that they experienced moderate pain. The licensee was made aware of the incident at the time this incident occurred and the SDM was not immediately notified.

Inspector interviewed RN # 106 who told the inspector, the expectation is that the incident should have been documented in the progress notes on the day that it occurred and that the SDM should have been notified immediately. RN # 106 confirmed that the SDM was not immediately notified.

Inspector interviewed S # 101 who also confirmed that the SDM was not immediately notified of the incident. [s. 97. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed immediately, in as much detail as is possible in the circumstances, of an incident of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Inspector reviewed a Critical Incident report related to a disease outbreak in the home.

Inspector reviewed the Infection Control binder and identified that a staff member reported that there were seven residents in the home who exhibited cold symptoms. These symptoms were coughing, congestion and general malaise. These residents were immediately placed on infection control practices.

Administrator # 100 confirmed that the respiratory outbreak occurred and it was not immediately reported to the Director. [s. 107. (1)]

Issued on this 20th day of January, 2016

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

Original report signed by the inspector.