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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
May 18, 2016	2016_269627_0008	005658-16	Resident Quality Inspection

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

SYLVIE BYRNES (627), FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 29, March 1-4, and March 7- 10, 2016.

The Inspectors conducted concurrent inspections for Complaint/Critical Incident reports related to allegations of staff abuse to a resident, medication adverse reaction, falls and hospitalization and improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co Director of Care (Co-DOC), Environmental Service Manager, Nutrition Manager, Staff Educator, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

The Inspectors also reviewed various policies, plans of care and other documentation within the home, conducted a daily walk through the care areas, observed staff to resident interactions and the delivery of care and services to the residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident Report was submitted to the Director, which alleged staff to resident neglect. A review of the documentation from the home's investigation revealed that the alleged incident occurred on a specific date in 2016, but was only reported by PSW #126, four days after the incident occurred.

A review of the "Resident Rights, Care and Services-Abuse Policy" revised March 26, 2015, identified the following: "Staff members, volunteers, substitute decision-makers, family members or any other person who has reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most senior administrative personnel on site at the home." The policy also identified the following: Staff Orientation and Training- During orientation and annually thereafter, all staff members will receive education on various topics including, but not limited to the following:
- The Resident's Bill of Rights
- The Home's Zero Tolerance Policy for Abuse and Neglect of Residents.

A review of the Relius online education course completion history revealed that PSW #127 had not completed the Resident's Bill of Rights education for 2015.

An interview with the Staff Educator confirmed that all staff was required to complete the Resident's Bill of Rights education for 2015, and that PSW #127 had not completed this.

An interview with the Administrator confirmed that it was the expectation of the home that any alleged or suspected incident of neglect of a resident was to be immediately reported to management personnel, and that this was not done. [s. 20. (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 the Resident Rights, Care and Services-Abuse Policy is complied with. Specifically, that every suspected abuse or neglect of a resident is reported immediately to the Director. All staff members will receive education on various topics including, but not limited to the following upon orientation and annually:
- The Resident's Bill of Rights
- The Home's Zero Tolerance Policy for Abuse and Neglect of Residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Family Council in the development and carrying out of the satisfaction survey, and in acting on its results.

During an interview, a member of the Family Council stated that the Council was asked to review the survey questions in 2014, and provided feedback. During the same interview, it was stated that the Family Council was not approached in 2015.

A review of the Administrator's reply to the November 12, 2014, Family Council minutes revealed the following statement: "Regarding the Abaqis interview questions, I have forwarded your concerns and suggestions on to the two individuals at head office who are heading up the this project. At this time I have no further information in this area to supply to you."

During an interview, the Administrator confirmed that the Family Council was not asked to review the survey in 2015, as the questions had not been changed from the survey in 2014, and that the Council was not asked for input on how to carry out the survey or how to act on the results. The Administrator further confirmed that there was no follow up with the Family Council regarding their concerns of the survey from 2014. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Resident Council in the development and carrying out of the satisfaction survey, and in acting on its results.

During an interview, a member of the Resident Council stated that the Council was not asked to review the survey, nor were they asked for input on how to carry out the survey or for advice on acting on its results.

During an interview, the Administrator confirmed that the Resident Council was not asked to review the survey in 2015, as the questions had not been changed from the survey in 2014, and that the Council was not asked for input on how to carry out the survey or how to act on the results. [s. 85. (3)]

3. The licensee has failed to ensure that the results of the satisfaction survey were documented and made available to the Family Council.

During an interview, a member of the Family Council stated they were not provided with the results of the satisfaction survey in 2014 and 2015.

An interview with the Administrator confirmed that the results of the satisfaction surveys were not provided to the Family Council. [s. 85. (4) (a)]

4. The licensee has failed to ensure that the results of the satisfaction survey were documented and made available to the Resident Council.

During an interview, a member of the Resident Council stated they were not given the results of the satisfaction survey in 2014 and 2015.

An interview with the Administrator confirmed that the results of the satisfaction survey were not provided to the Resident Council. [s. 85. (4) (a)]

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 the Licensee seeks the advice of the Family and Resident Councils in the development and carrying out of the satisfaction survey, and in acting on its results. The results of the satisfaction survey will be documented and made available to the Family and Resident Councils, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Inspector #627 observed a medication pass on March 7, 2016, at 1130 hours.
The Inspector observed RN #116 administer a medication to resident #004, #014, then proceeded to provide a treatment to another resident and administer a medication to them. RN #116 had not performed hand hygiene between these tasks. The Inspector observed that the hand sanitizer was located on the side of the medication cart, out of RN #116's view.

The Inspector observed a medication pass on March 7, 2016, at 1145 hours.
The Inspector observed that RPN #117 administered medication to resident #020, #021, #022 and #023 and noted that RPN #117 had not performed hand hygiene in between administering medications to these four residents. The Inspector observed that the computer screen was obstructing the hand sanitizer from RPN #117's view and that it was not accessible and in easy reach to be used.

During an interview, RN #116 and RPN #117 stated that it was the home's expectation that hand hygiene be performed before and after every resident contact and this was not done.

During an interview with Co-DOC #111, they confirmed that it was the expectation that all staff members practice hand hygiene and infection prevention control practices. Co-DOC #111 also stated that the hand sanitizer should have been in view of the staff members and within easy reach as a reminder to sanitize their hands. [s. 229. (4)]

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 hand hygiene program is complied with, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A review of the Doctor's post admission orders for resident #001 indicated they were to receive a specific treatment.

A review of the Electronic Medication Administration Record (EMAR) indicated that the specific treatment was provided to resident #001.

A review of the care plan failed to reveal any goals, focus or interventions for the specific treatment.

During an interview, RPN #115 stated that resident #001's plan of care had not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #007 was identified as having a certain medical condition during Stage 1 of the

RQI.

The Physician had examined resident #005 as their condition had worsened. After a discussion with the family, it was decided that resident #005 would receive palliative care.

The Inspector reviewed resident's #005's progress notes and identified that resident #005's health had declined. It was also noted that the resident required total assistance from the PSW with all the Activities of Daily Living (ADLs). The progress notes further indicated that resident #005 had required interventions and certain equipment for assistance due to the change in their medical condition.

A review of the care plan indicated that resident #005 "required minimal assistance for certain aspects of their care". According to the same care plan, resident # 005 required "minimal assistance with other aspects of their care". Under another focus, resident #005 received "minimal interventions". Furthermore, the care plan had not addressed a specific treatment that the resident was receiving.

During an interview, PSW #125 stated that resident #005's condition had begun to decline on an earlier date, and further declined a few days after. Resident #005 now required total assistance with all their ADLs. PSW #125 also stated that the Physiotherapist had assessed the resident and that they now required a specific aid for safe transfers. As well, the resident was receiving a specific treatment for comfort measures. PSW #125 confirmed that they had reported these change to the registered staff when this was first noted.

During an interview, RN #129 stated that they were not aware that resident #005 was receiving a specific treatment for comfort. RN #129 confirmed that the care plan had not addressed the specific treatment and should have.

During an interview, the DOC and Co-DOC #122 stated that it was the home's expectation that any change in condition of a resident was to be immediately reported to the registered staff. The registered staff was to update or revise the resident's care plan. They both confirmed that resident #005 had a significant change in their condition and the care plan was not updated or revised to reflect the changes and should have been. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum of 22 degrees Celsius.

During an interview, resident #002 stated that they found their room and bathroom to be very cool and at times cold. They stated this occurred continuously during the colder months.

Inspector #627 noted at the time of the interview that it was cool in the room and even cooler in the bathroom.

Temperatures taken by Inspector #627 on March 3, 2016, at 1340 hours, in resident #002's room indicated that the room temperature beside the chair which was located near the window was 20.7 degrees Celsius. At this time, the bathroom temperature was 19.6 degrees Celsius. PSW #101 confirmed the temperature readings with the Inspector and stated the room was cool.

Temperatures taken by Inspector #627, at 0840 hours, in resident #002's room indicated that the temperature was 20.9 degrees Celsius and the bathroom temperature was 19.6 degrees Celsius. RPN #109 confirmed the temperature with the Inspector.

During an interview, the Environmental Service Manager stated that the heat control in the residents' rooms were locked but in the specific room, the box had been altered and the temperature was lowered to 18 degrees. [s. 21.]

WN #6: 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. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written medication management policies and protocols were implemented.

Inspector #544 reviewed a Critical Incident Report that was submitted to the Director, related to two missing narcotic tablets. According to the report, the day shift RPN #103 (off going nurse) counted the narcotics with the afternoon shift RN (on coming nurse) when it was discovered that two narcotic tablets were missing.

A review of the home's investigation notes indicated, that it was discovered that the night shift RN #104, (on coming nurse), stated that they had not counted the narcotics with the afternoon shift RN #107. Similarly, the next day, the day shift RPN #103 (on coming nurse) had not counted the controlled medication with RN #104 (off going nurse). The police were notified, and through their investigation it could not be identified when the two narcotic tablets went missing. The police removed the remainder of the specific narcotic tablets off the premises as the medication had been discontinued. RN #104 and RPN #103 admitted to the previous DOC that they had not counted the narcotics at the end of each shift.

A review of the home's "Medication Management Policy- Narcotics and Controlled Substances" by Inspector #544 revealed: "A count of all narcotics shall be completed by the off going and on coming Registered Staff at the change of shift or whenever an exchange of medication keys takes place."

During an interview, the DOC confirmed that RN #103 and RN #104 failed to conduct the narcotic count with the off going and on coming Registered staff and that they had not followed the home's policy regarding the narcotic count, and should have. [s. 114. (3) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

On March 8, 2016, Inspector #544 observed five outdated bottles of a medication in the medication room of a Home Area. The expiry date on these bottles was January 2016. The Inspector also noted that resident #118 had a medication that had expired in February 2016. This was confirmed by RPN #117 who stated that these medications should have been discarded and were not.

On March 8, 2016, Inspector #544 observed three outdated bottles of medication in the medication room of a Home Area. The expiry date on these bottles was January 2016. This was confirmed by RPN #118 who stated that these medications should have been discarded and were not.

The Inspector reviewed the refrigerator temperatures that had been taken for a medication refrigerator in a Home Area and identified that on March 6, 2016, the temperature had registered 1.4 degrees Celsius. The Inspector also identified that the refrigerator temperature went above eight degrees Celsius nine times between February 18, 2016, to March 6, 2016, and that there was no temperature recorded for March 5, 2016. The refrigerator contained a specific medication and another injectable medication, both which were to be stored between two and eight degrees Celsius.

In another Home Area, Inspector #544 noted that there were no refrigerator temperatures taken to ensure that the efficacy of the medications in the refrigerator was maintained. The refrigerator contained two types of injectable medications which were to be stored between two and eight degrees Celsius. The Inspector examined the memory temperatures that were automatically recorded by the thermometer and identified that the temperature of the refrigerator registered as high as 21 degrees Celsius.

During an interview, RPN #118 stated that they were not aware of the temperature ranges and had not notified anyone when the temperatures were below two degrees Celsius or above eight degrees Celsius.

During an interview, RN #116 stated that they were not aware that the refrigerator temperatures had to be taken daily or twice daily and confirmed that they had not taken any refrigerator temperatures. RN #116 also stated that there were no forms in the medication room to document and monitor the refrigerator temperatures.

During an interview, Co-DOC #111 stated that it was the expectation of the home that refrigerator temperatures were to be taken at least once daily. She confirmed that a certain Home Area had not recorded and documented any refrigerator temperatures at least daily and should have. [s. 129. (1) (a) (iv)]

2. The licensee has failed to ensure that controlled substances were stored in a separate locked area within a locked medication cart.

On March 7, 2016, Inspector #544 observed an unlocked medication cart which contained controlled substances, stored in a locked medication room in two home areas.

During an interview, RN #116 stated that they never locked the medication cart when it was in the medication room.

During an interview, RPN #117 stated that they had not always locked the medication cart in the medication room, and were not aware that this was necessary.

During an interview, Co-DOC #111 confirmed that the expectation was that each medication cart was to be locked when not in use, and when in the locked medication room. [s. 129. (1) (b)]

Issued on this 7th day of June, 2016

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

Original report signed by the inspector.