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

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
May 4, 2017	2017_638609_0005	030238-16, 000301-17, 000307-17, 000308-17, 000309-17, 000310-17	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

CHAD CAMPS (609)

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): March 6-10, 2017.

This follow up inspection is related to a Compliance Order (CO) related to compliance with the home's zero tolerance of abuse and neglect policy.

A Critical Incident Inspection #2017_638609_0006 and a Complaint inspection #2017_638609_0007 were conducted concurrently with this inspection.

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

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' healthcare records, staffing schedules, staff training records, components of human resource files, internal investigations, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

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 #002	2016_483637_0014	609
O.Reg 79/10 s. 221. (2)	CO #005	2016_483637_0014	609
O.Reg 79/10 s. 50. (2)	CO #003	2016_483637_0014	609
O.Reg 79/10 s. 52. (2)	CO #004	2016_483637_0014	609
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #001	2016_483637_0014	609

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 :

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

During inspection #2016_429642_0009 a Compliance Order (CO) was issued to the home on October 6, 2016, to address the licensee's failure to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20.(1). related to PSW #104's substantiated abuse toward a resident.

The CO required the licensee to have ensured that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

Full compliance of the CO was expected by October 28, 2016.

A review of the home's policy titled "Resident Rights, Care and Services- Abuse- Zero Tolerance- Staff Acknowledgement" last revised March 23, 2015, indicated that residents had the right to live free from abuse and neglect.

A review of PSW #104's human resource file since the CO was issued to the home found the following:

-On a particular day, PSW #104 was rough and verbally abused resident #007. For this they received disciplinary action; and

-On two other particular days, PSW #104 was rough with resident #009 and #010 who complained that the PSW hurt them several times throughout the specified days. For this PSW #104 received additional disciplinary action.

During an interview with the DOC they verified that PSW #104 was verbally and physically abusive towards residents in the home on three particular days, and did not comply with the home's zero tolerance of abuse and neglect of residents policy. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On a particular day, the door to tub room #243 was found open and unattended by staff. The door remained open and unattended for five minutes before the Inspector notified staff of the risk.

During an interview with PSW #103, they verified that the tub room doors were to be kept closed and locked when not being used by staff. PSW #103 promptly closed and locked the door to tub room #243.

A review of the home's policy titled "Resident Rights, Care and Services- Safe and Secure Home- Door Alarms" effective date September 16, 2013, found no direction was provided to staff related to non-residential area doors that did not lead to stairways or exits.

During an interview with Co-DOC #100, they verified that doors to the home's tub rooms were to be kept closed and locked when not attended by staff. [s. 9. (1) 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 all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: 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 improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm, 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 had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

A review of PSW #104's human resource file since a CO was issued to the home on October 6, 2016, related to the PSW's abusive conduct toward a resident found that on

three particular days PSW #104 was verbally and physically abusive towards three residents.

A review of the home's policy titled "Resident Rights, Care and Services- Abuse- Zero Tolerance- Staff Acknowledgement" last revised March 23, 2015, indicated that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident, 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 had occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director.

During an interview with the DOC, they verified that they became aware of one of the incidents on the same day it occurred when PSW #106 verbally reported the abuse to Co-DOC #100. The home became aware of the two other incidents three days after they occurred, when PSW #105 gave Co-DOC #100 a written letter outlining the allegations.

The DOC indicated that the incidents were not reported to the Director because there were no identified injuries to the residents.

A review of the Ministry's Reporting of Abuse and Neglect Decision Trees were conducted with the DOC, who verified that when the home became aware of incidents that caused pain to a resident by staff from the use of inappropriate or excessive force or verbal communication toward a resident that was threatening or intimidating, they should have immediately reported to the Director.

The DOC verified that once the home became aware of the incidents, they should have immediately reported the suspicion and the information upon which they were based to the Director.

During an interview with the Administrator, they verified that the CIs related to the incidents on the three specified days would be submitted to the Director. [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 improper or incompetent treatment or care of a resident that results in harm or a risk of harm, abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or a risk of harm to the resident has occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 24th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609)
Inspection No. / No de l'inspection :	2017_638609_0005
Log No. / Registre no:	030238-16, 000301-17, 000307-17, 000308-17, 000309-17, 000310-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 4, 2017
Licensee / Titulaire de permis :	VALLEY EAST LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	ELIZABETH CENTRE 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELLY MURPHY

To VALLEY EAST LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_429642_0009, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

a) Ensure that the home's policy to promote zero tolerance of abuse and neglect of residents is complied with by all staff.

b) Specifically ensure that residents are safeguarded from any other abuse by PSW #104.

c) Ensure that residents are safeguarded from any other staff member substantiated to have abused residents and continue to work within the home.

Grounds / Motifs :

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

During inspection #2016_429642_0009 a Compliance Order (CO) was issued to the home on October 6, 2016, to address the licensee's failure to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20.(1). related to PSW #104's substantiated abuse toward a resident.

The CO required the licensee to have ensured that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

Full compliance of the CO was expected by October 28, 2016.

A review of the home's policy titled "Resident Rights, Care and Services- Abuse- Zero Tolerance- Staff Acknowledgement" last revised March 23, 2015, indicated that residents had the right to live free from abuse and neglect.

A review of PSW #104's human resource file since the CO was issued to the home found the following:

-On a particular day, PSW #104 was rough and verbally abused resident #007. For this they received disciplinary action; and

-On two other particular days, PSW #104 was rough with resident #009 and #010 who complained that the PSW hurt them several times throughout the specified days. For this PSW #104 received additional disciplinary action.

During an interview with the DOC they verified that PSW #104 was verbally and physically abusive towards residents in the home on three particular days, and did not comply with the home's zero tolerance of abuse and neglect of residents policy.

The scope of this issue was determined to have been isolated to PSW #104's conduct. There was a previous Voluntary Plan of Correction (VPC) issued related to this provision during inspection #2016_269627_0008 on May 18, 2016. There was an additional related CO issued to the home on October 6, 2016, during inspection #2016_429642_0009. The severity was determined to have been actual harm to the health, safety and well-being of residents #007, #009 and #010 who were abused by PSW #104's non-compliance with the home's zero tolerance of abuse and neglect policy. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 26, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

Service Area Office /
Bureau régional de services : Sudbury Service Area Office