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
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159 rue Cedar Bureau 403
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 10, 2018	2017_657681_0018	012988-17, 026040-17	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

STEPHANIE DONI (681)

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 18-22, 2017.

The following intakes were completed during this Critical Incident System (CIS) inspection:

- One intake related to the unexpected death of a resident.

- One intake related to resident to resident abuse.

An Other inspection #2017_657681_0019 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care, Food Services Manager, Staff Development Coordinators, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, residents, and a Consumer Care Specialist.

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

A Critical Incident System (CIS) report was submitted to the Director about the unexpected death of resident #001. The CIS report indicated that resident #001 was eating when they alerted PSW #105 that they were choking. Resident #001 then became unresponsive and subsequently passed away.

Inspector #681 reviewed resident 001's care plan, which indicated that the resident was to be provided with a specific diet texture and specific nutrition related interventions.

Inspector #681 reviewed the Diet Spreadsheet for a particular menu cycle for both meals and snacks. The Diet Spreadsheet for snacks indicated that a particular food item was an acceptable option for a resident who required a specific diet texture. However, the Diet Spreadsheets for meals indicated that the same food item needed to be altered before it could be served to a resident who required that specific diet texture.

During an interview with Inspector #681, Food Services Manager #103 acknowledged that there were some discrepancies between the diet spreadsheets for meals and the diet spreadsheets for snacks. Food Service Manager #103 stated that there could be clearer guidelines on the diet spreadsheets, especially for snacks. Food Services Manager #103 also stated that they believed that a specific nutrition intervention present in resident #001's care plan would only be an applicable at meals and not necessary at snacks.

Inspector #681 reviewed the home's internal investigation notes related to the incident, which included notes from a telephone interview between the DOC and RD #101. The investigation notes indicated that when the DOC asked RD #101 if a particular snack choice was appropriate for resident #001, RD #101 stated that it would be dependent on the individual and that it would be less of a risk if the particular food item was consumed with a beverage. When RD #101 was advised that this resident refused a beverage, RD #101 stated there was a risk.

During an interview with Inspector #681, RD #101 stated that foods of a specific diet texture were altered prior to serving so that they had specific characteristics. RD #101 stated that the particular food item would not have had the identified characteristics. RD #101 also stated that they had recently assessed resident #001 and no concerns were identified regarding resident #001's ability to tolerate their current diet texture. However,

RD #101 stated that they could not recall if they observed resident #001 eat when they completed their recent assessment and there was no documentation in resident #001's electronic medical record to indicate that an observation had been completed. [s. 11. (2)]

2. During the inspection related to the unexpected death of resident #001, Inspector #681 observed the preparation of the evening snack carts in the main kitchen on December 19, 2017. Inspector #681 observed one full jug of thickened water dated December 8, 2017, one jug of thickened water dated December 14, 2017, and one jug of thickened cranberry juice dated December 14, 2017. These beverages had come off the supper beverage carts and were being put on the evening snack carts.

During an interview with the Inspector, Dietary Aide #112 stated that thickened beverages were prepared in house using powdered thickener. Dietary Aide #112 verified that the stickers on the beverages meant that these beverages were prepared on December 8, 2017 (11 days prior to the Inspector's observation), and December 14, 2017 (five days prior to the Inspector's observation), respectively. Dietary Aide #112 stated that thickened fluids keep for approximately one week and stated that they were used by kitchen staff until they changed consistency and became too thick.

During an interview with Inspector #681, Food Services Manager #103 stated that thickened fluids prepared in house had a 24 hour window before they should be discarded. Food Services Manager #103 stated that thickened fluids did not last 24 hours in the home because of the rate at which they were consumed by residents.

Inspector #681 reviewed the home's policy titled "Thickened Fluids", last revised November 18, 2014, which did not indicate how long thickened fluids could be stored once they had been prepared. Inspector #681 also reviewed the product directions for Resource Thicken Up, which was the thickening agent used by the home to thicken food and beverages. The product directions did not provide any indication of how long thickened beverages could be stored for once prepared.

Inspector #681 contacted the manufacturer of the thickening agent and spoke with a Consumer Care Specialist who indicated that, once prepared, thickened beverages need to be covered and could be refrigerated for up to 12 hours. Any product that had been stored longer than 12 hours must be discarded.

In a subsequent interview with Inspector #681, Food Services Manager #103 indicated that the policy titled "Thickened Fluids" had been updated to indicate that all fluids not

used within a 24 hour period must be discarded. [s. 11. (2)]

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 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 policy for zero tolerance of abuse and neglect was complied with.

Ontario Regulation 79/10 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A CIS report was submitted to the Director related to an allegation of resident to resident sexual abuse. The CIS report indicated that resident #003 acted inappropriately towards resident #002.

During an interview with Inspector #681, resident #002 reported that resident #003 would act inappropriately. Resident #002 stated that they did not like when these incidents occurred and that they always reported these incidents to staff members at the home.

During an interview the Inspector, RPN #115 stated that on a particular date, resident #002 reported that resident #003 had acted inappropriately. RPN #115 stated that when they spoke with resident #002, resident #002 was weepy. RPN #115 stated that they reported the incident to the Charge RN and left a message for the manager on call on their office answering machine.

Inspector #681 reviewed the home's policy titled "Resident Abuse and Neglect – Zero Tolerance Policy for Resident Abuse and Neglect", which indicated that suspected abuse or neglect of a resident must be immediately reported to the most Senior Administrative Personnel or Charge Nurse if no manager was on site at the home and, that if the allegation of abuse or neglect was with the Charge Nurse because no manager was on-site at the Home, the Administrator or Director of Care was to be notified so that they could immediately report the suspected incident of abuse to the Ministry and Health and Long-Term Care.

During an interview with the Inspector, Staff Development Coordinator #110 stated that they became aware of the incident when they retrieved the message that was left on their answering machine by RPN #115. Staff Development Coordinator #110 stated that RPN #115 should have notified the Charge RN, who then should have immediately contacted the manager on call so that the incident could have been reported to the Director.

During an interview with the Inspector, the Administrator stated that the RN in charge should have notified the manager on call immediately so that the Director could be notified about the incident through the Ministry's after hours pager. [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 home's policy for zero tolerance of abuse and neglect is complied with, specifically that all staff immediately report allegations or suspicions of resident abuse as per the home's policy, to be implemented voluntarily.

Issued on this 10th day of January, 2018

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) :	STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2017_657681_0018
Log No. / No de registre :	012988-17, 026040-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 10, 2018
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 :	Chantal Carriere

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan for ensuring that all residents are provided with food and fluids that are safe, adequate in quantity, nutritious, and varied. The plan shall include, but not limited to include the following:

a) Review all of the residents in the home who are receiving a texture modified diet to ensure that food and beverage choices, including snack choices, on the planned menu are appropriate and safe for each of these residents to consume. Documentation related to this review must be maintained.

b) Educate all dietary staff, PSWs, RPNs, and RNs about appropriate food choices for residents receiving texture modified diets.

c) Ensure that nursing and dietary staff have clear and specific instructions about residents' dietary requirements readily accessible during all meal and snack services.

d) Educate dietary staff about the principles of safely storing food and beverages.

This plan may be submitted in writing to Long Term Care Homes Division at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, this plan may be emailed or faxed. This plan must be received by January 24, 2018, and fully implemented by March 30, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

A Critical Incident System (CIS) report was submitted to the Director about the unexpected death of resident #001. The CIS report indicated that resident #001 was eating when they alerted PSW #105 that they were choking. Resident #001 then became unresponsive and subsequently passed away.

Inspector #681 reviewed resident 001's care plan, which indicated that the resident was to be provided with a specific diet texture and specific nutrition related interventions.

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#001 and no concerns were identified regarding resident #001's ability to tolerate their current diet texture. However, RD #101 stated that they could not recall if they observed resident #001 eat when they completed their recent assessment and there was no documentation in resident #001's electronic medical record to indicate that an observation had been completed. [s. 11. (2)]

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Inspector #681 contacted the manufacturer of the thickening agent and spoke with a Consumer Care Specialist who indicated that, once prepared, thickened beverages need to be covered and could be refrigerated for up to 12 hours. Any

product that had been stored longer than 12 hours must be discarded.

In a subsequent interview with Inspector #681, Food Services Manager #103 indicated that the policy titled "Thickened Fluids" had been updated to indicate that all fluids not used within a 24 hour period must be discarded.

During a previous inspection (#2017_655679_0008), a Written Notification (WN) was issued to the home on September 8, 2017, related to licensee having failed to ensure that residents were provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. A Voluntary Plan of of Correction (VPC) was also issued during the same inspection related the the licensee having failed to ensure that the home's menu cycle was approved by a registered dietitian who was a member of the staff of the home. The decision to issue a compliance order was based on the severity, which indicated actual harm/risk to the residents of the home, and scope, which identified a pattern throughout the home. Furthermore, the home's compliance history identified ongoing noncompliance with related legislation. (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Stephanie Doni

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