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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2019	2019_679638_0003	008978-18, 009804-18, 013923-18, 016867-18, 018416-18, 020915-18, 021967-18, 022164-18, 022607-18, 023286-18, 024499-18, 027837-18, 032780-18, 032910-18	Critical Incident System

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

RYAN GOODMURPHY (638), AMY GEAUVREAU (642), CHAD CAMPS (609)

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): January 7 - 11 and 14 - 18,

2019.

The following intakes were inspected during this CIS inspection;
-Four logs were critical incident reports the home submitted to the Director regarding alleged staff to resident abuse;
-One log was related to a critical incident report the home submitted to the Director regarding a fall which resulted in an injury;
-Two logs were critical incident reports the home submitted to the Director related to missing medications;
-Six logs were critical incident reports the home submitted to the Director related to resident to resident sexual abuse; and
-One log was related to a critical incident report the home submitted to the Director regarding resident to resident physical abuse.

A Follow Up inspection #2019_679638_0001 and a Complaint inspection #2019_679638_0002, were conducted concurrently with this Critical Incident Systems inspection.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 20 (1) was identified in this inspection and has been issued in Inspection Report 2019_679638_0002, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Environmental Manager, Consulting Nutrition Manager, Culinary Manager, Resident and Family Services Coordinator (RFSC), Life Enrichment Coordinator (LEC), Staffing Coordinator, Staff Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitians (RD), Dietary Aids (DA), Housekeeping Aids, residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant personnel files, licensee policies, procedures, programs, relevant training and health care records.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

A CIS report was submitted to the Director which alleged that resident #004 felt that a specific staff member was not completing all required care and alleged neglectful care with regards to a part of their specific care interventions and Activities of Daily Living (ADL) routine.

Inspector #638 reviewed resident #004's health care records and identified in their care plan that the resident required specific care at specific times throughout the day. The care plan further indicated that the PSW was to assist the resident to complete the specific care. The Inspector reviewed the resident's physician orders and identified an order which directed staff to provide the resident with the specified care (identified in their care plan) at specific times throughout the day.

In an interview with Inspector #638, resident #004 stated that staff assistance with care has improved, however, staff usually only performed the resident's specific physician ordered care intervention once a day.

A) Inspector #638 observed resident #004 during the lunch meal service for one and a half hours. The Inspector did not observe any staff perform the specific physician ordered care on resident #004. The Inspector reviewed the resident's electronic medication administration record (eMAR) and identified that RPN #121 documented that the resident received their specific physician ordered care intervention. In an interview with resident #004, they stated that staff had not performed the specific physician ordered care intervention.

In an interview with Inspector #638, PSW #137 indicated that resident #004 required assistance for all care. The PSW stated that they provided the resident with assistance with the specific physician ordered care intervention consistently at one of the specified times, but the resident usually refused the care intervention at a different time. The PSW stated that the care plan identified the specific care was supposed to be provided at specific times throughout the day as an intervention, as it was the physician's direction, but the resident often refused. When asked if they performed the specific physician ordered intervention on resident #004, as per their plan of care, they stated they did not offer the specific physician ordered care intervention to be completed.

During an interview with Inspector #638, RPN #121 indicated that the PSWs administered resident #004's specific physician ordered care intervention and the RPN

would document care as given by the PSW. The Inspector reviewed administration record times with the RPN, who stated they did not wait to ensure that the intervention was provided prior to documenting the care as completed. The RPN indicated they had "a good team", who ensured all care was completed and therefore they documented early. Upon reviewing the observations and findings of the Inspector with the RPN, they stated this was worrisome because they were now questioning how much care was potentially missed.

B) Inspector #638 observed resident #004 at a specific time leaving the dining room after completing the meal service. The Inspector reviewed resident #004's eMAR and identified that the resident's specific physician ordered care intervention was documented by RPN #139, as completed almost 40 minutes earlier.

In an interview with Inspector #638, RPN #139 indicated that they were administering medications on the home area, until the scheduled RPN #141 arrived. Upon reviewing the documentation report with the RPN, they indicated that they did not give resident #004 their medications this morning and that RPN #141 must have documented care provided under RPN #139's credentials.

During an interview with Inspector #638, RPN #141 indicated that they took over for RPN #139 at an identified time. The RPN indicated that they remained logged into RPN #139's eMAR by accident and documented some of their medication pass under the other RPN's credentials. The RPN stated they administered resident #004's medications and had indeed documented the resident's specific physician ordered care intervention as given, prior to administering the resident's medication. The RPN indicated that they were aware this was wrong but were attempting to complete all required care and stated they knew to go back and provide the care after the resident finished their meal.

In an interview with Inspector #638, the DOC stated that direct care staff followed resident specific care plans and interventions. The Inspector reviewed resident #004's health care records with the DOC, who indicated that the resident had a specific physician ordered care intervention at specific times throughout the day. The Inspector then reviewed their observations with the DOC, who then indicated that staff should have followed the resident's planned care and not documented interventions as completed, prior to the time the care was provided. [s. 131. (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 resident #004 receives their specific physician ordered care intervention in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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 every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A CIS was reported to the Director, which alleged that resident #003 was taken out of the dining room by PSW #101 on a specific date and was placed down the hallway in their mobility assistance device, positioned in a manner which prevented the resident from mobilizing. The CIS report alleged that the resident felt they were being "treated like a dog".

Inspector #638 reviewed the home's investigation notes and noted an interview held with PSW #101. The notes identified that they had removed resident #003 from the dining room on a specific date and positioned the resident in a specific manner in their mobility assistance device. The PSW stated that the resident asked "Why can't I, I can go myself" and the PSW responded by telling the resident they can't go on their own and they would get to the resident when they were done feeding residents in the dining room.

The Inspector identified documentation of an interview held with resident #003. The interview with the resident stated that they were positioned in a specific way in their mobility assistance device by a PSW. During the interview the resident stated that they "wanted to know why. I didn't do nothing wrong, why do you [position] me, so I don't run away? I don't understand".

The Inspector reviewed resident #003's plan of care, in effect at the time of the incident and was unable to identify any notation which directed staff to position the resident in a specific manner while in their mobility assistance device, at any time.

In an interview with Inspector #638, resident #005 indicated that they used a specific mobility device for mobility. The resident identified that they could mobilize independently in their device and they did not want to be positioned in the specific manner while using their mobility assistance device, because they found it frightening.

During an interview with Inspector #638, PSW #109 indicated that they were working on the date of the incident and stated that PSW #101 pushed resident #003 down the hallway, positioned the resident in their mobility assistance device and restricted movement of the resident. The PSW indicated that the resident mobilized independently in their mobility assistance device at the time of the incident and were not supposed to be positioned in the specific manner, they were positioned on the date of the incident. The PSW indicated that they felt the resident rights were infringed upon because the resident was restrained as a result of these actions.

During an interview with Inspector #638, PSW #101 indicated that resident #005 was dependent on staff for all care and was able to mobilize independently, for short periods of time, in their mobility assistance device. The PSW indicated that they removed resident #005 from the dining room while assisting other residents with their meals. The PSW stated they placed the resident just outside of the dining room because they were becoming agitated and requesting to be put back to bed. The PSW indicated they were concerned the resident would attempt to transfer themselves if they went on their own and positioned the resident in a specific manner in their mobility assistance device until they could assist them.

Inspector #638 interviewed RN #127, who stated that all residents who had a specific mobility assistance device, could be repositioned for comfort. The RN indicated this was just done at times and was not based on any plan of care interventions.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2, 2017, defines emotional abuse as any threatening, insulting, intimidating or humiliating gesture, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. The policy states zero tolerance means that Jarlette Health Services shall: uphold the right of the residents of long-term care facilities to be related with dignity and respect within those facilities and to live free from abuse and neglect.

In an interview with Inspector #638, the DOC indicated that if a resident indicated they did not want to be positioned in a specific manner in their mobility assistance device and staff did so, for the sake of convenience, it could be restraining to the resident. The Inspector inquired if the DOC felt that the incident between resident #005 and PSW #101 infringed on the resident's rights due to the resident's reaction. The DOC stated yes, they felt that it did infringe on the resident's rights. [s. 3. (1) 1.]

Issued on this 30th day of January, 2019

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

Original report signed by the inspector.