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
Apr 8, 2019	2019_657681_0009	002340-19, 004301-19	Complaint

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

STEPHANIE DONI (681), AMY GEAUVREAU (642)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 18 - 22, 2019, and March 25 - 29, 2019.

The following intakes were inspected during this Complaint inspection:

- Two intakes related to resident care concerns and the staffing levels in the home.

A Follow Up inspection #2019_657681_0007, a Critical Incident inspection #2019_657681_0008, and an Other inspection #2019_657681_0010 were conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance related to s. 8 (1) (b) of the LTCHA, 2007, was identified in this inspection and has been issued in Inspection Report #2019_657681_0007, dated April 8, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Care Service Coordinator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Staff Educators, Restorative Care Coordinator, Staffing Coordinator, Life Enrichment Staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) RPN, Personal Support Workers (PSWs), family members, and residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Responsive Behaviours

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

- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Director related to the falls that resident #007 had sustained.

Inspector #681 reviewed resident #007's current plan of care, which indicated that resident #007 had a specified falls prevention intervention.

On a specified date, the Inspector observed resident #007 and noted that the specified falls prevention intervention was not in place. During an interview with PSW #120, they confirmed that resident #007 did not have the specified falls prevention intervention in place, and that the intervention should have been implemented.

On another specified date, the Inspector again observed resident #007 without the falls prevention intervention. During an interview with PSW #133, they stated that resident #007's falls prevention intervention was not in place and that it should have been implemented.

During an interview with the Restorative Care Coordinator, they stated that resident #007 was to have a specified falls prevention intervention and that, if the intervention was not in place, then care was not provided to the resident as per their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was submitted to the Director related to resident #007 not having received their scheduled bathing choice due to insufficient staffing.

Inspector #642 reviewed the bath assignment sheet for a specified Home Area. The bath assignment sheet identified that the residents #007 and #015 were to receive their bathing choice on two specified days of the week.

The Inspector reviewed the Point of Care (POC) documentation for residents #007 and #015 and identified that neither of the residents had POC documentation completed for their bathing choice on three specified dates in March 2019.

During interviews with PSW #137, RPN #136, and RN #117, they indicated that documentation related to the resident's bathing choice would be in POC, on the document titled “Daily Home Area Record", on a “Bath Audit Form”, or in a progress note in the resident's health care record.

Inspector #681 reviewed the progress notes in resident #007's and resident #015’s health care record for a specified period of time and was unable to identify any documentation regarding their bathing choice. Inspector #642 reviewed the “Daily Home Area Records" and requested bath audit sheets for the three specified dates in March 2019. Inspector #642 also found no documentation related to the bathing choice for residents #007 or #015 on these specified dates.

Inspector #642 interviewed the Staffing Coordinator, who stated that PSW #127 and PSW #116 worked in the specified Home Area on the three particular dates in March 2019.

Inspector #642 interviewed PSW #127 and PSW #116 who stated that they were assigned to complete the resident's bathing choice for the specified Home Area on the three particular dates in March 2019. Both PSWs stated that the Home Area was short staffed on these dates. PSW #127 and #116 stated that they completed the bathing choice for residents #007 and #015, but because the Home Area was shorted staffed, they did not have time to document the completed bathing choice for these residents. PSW #127 and #116 acknowledged that, because there was no documentation, it was not clear if the residents were provided with their bathing choice on these dates.

Inspector #642 reviewed the home's policy titled, "Resident Rights, Care and Services-Nursing and Personal Support Services-Personal Care," effective date, September 16, 2013, which indicated that the provision of personal care was to be documented in keeping with set standards of the home.

The Inspector interviewed Co-DOC #102 and Co-DOC #103, who each stated that the provision of personal care for residents must be documented. The Co-DOCs stated that baths were supposed to be documented in the POC, in a progress note, on the "Daily Home Area Record", or on the Bath Audit Form. The Co-DOCs stated that if there was no documentation in these locations, then the resident's bathing choice was not documented. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.