Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Jul 12, 2019	2019_771609_0009	006486-19, 008146-19, 010620-19, 012037-19	Critical Incident System

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 711 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), STEVEN NACCARATO (744)

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): June 17-21, 23, 25-28, 2019.

The following intakes were inspected during this Critical Incident System (CIS) inspection:
-Three intakes related to resident falls; and
-One intake related to allegations of resident to resident abuse.

A Complaint inspection #2019_771609_0008 and a Follow-Up inspection #2019_771609_0007 were conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance related to section (s.) 6. (1) (c) and s. 6. (7) of the Long Term Care Homes Act (LTCHA), 2007 identified in this inspection and has been issued in Complaint inspection #2019_771609_0008.

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

The Inspector(s) also conducted a daily tour of the home, reviewed relevant resident care records, home investigation notes, home policies, personnel files, as well as the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. (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 resident #006 was reassessed and the plan of care 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.

A Critical Incident (CI) report was submitted to the Director regarding a fall of resident #006 that resulted in an injury. The incident report indicated the resident was walking without a specified intervention and lost their balance.

A review of resident #006's health care records by Inspector #744 identified the resident fell a specified number of times since their admission to the home.

A review of the progress notes for resident #006 indicated that the only physiotherapy assessment completed for the resident was at admission. Further review of the progress notes indicated that a specified number of physiotherapy assessments had been attempted but not completed.

A review of the home's policy titled "Resident Rights, Care and Services-Required Programs- Falls Prevention and Management- Program" last revised May 7, 2019, stated that the Restorative Care Coordinator/Physiotherapist would ensure that all residents were screened for falls risk through transfer/mobility assessments upon referral, quarterly and with significant change of condition.

In an interview with the Restorative Care Coordinator (RCC), they indicated that they had received referrals from nursing staff after resident #006's falls and relied on the physiotherapist to have completed the assessments. They further stated that concerns regarding resident #006's incomplete assessments were not communicated to them. They also indicated that collaboration between themselves and the physiotherapist may have facilitated the completion of the required physiotherapy assessments.

The home's physiotherapist was unavailable for an interview.

During an interview with Co-DOC #103, they stated that the physiotherapist failed to collaborate with the family of resident #006 and the RCC to ensure that the resident had physiotherapy assessments completed after each referral made by nursing staff. [s. 6. (10) (b)]

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 #006 as well as all other residents of the home are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 12th day of July, 2019

[redacted]

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

Original report signed by the inspector.