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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2019	2019_805638_0019	016649-19	Complaint

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

RYAN GOODMURPHY (638)

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): September 9 - 13, 2019.

The following intake was completed in this complaint inspection:
-One log, which was related to a complaint submitted to the Director regarding continence care concerns and call bell accessibility.

A follow up inspection #2019_805638_0020, was conducted concurrently with this complaint inspection.

Please note: Keara Cronin (Inspector #759) was also on-site throughout the course of the inspection.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Co-Directors of Care (DOC), Environmental Service Manager, Staffing Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), 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 licensee policies, procedures, programs, relevant training and resident health care records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

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. (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 provision of the care set out in the plan of care was documented.

A complaint was submitted to the Director which outlined continence care concerns for resident #001.

Inspector #638 reviewed resident #001's health care records and identified in the plan of care that the resident had a specific set of interventions for their continence care. The plan directed staff to provide the resident with specific assistance to maintain continence at set times and as needed throughout each shift. The intervention indicated that staff were supposed to record the implementation of this intervention, whenever it had been provided.

Inspector #638 reviewed the written record for resident #001 and identified two dates over the two week review period, where the resident was not recorded as receiving the scheduled care during a specific shift. There was no documentation to support when or if the resident was provided assistance, as per their care plan intervention.

The Inspector reviewed the documentation records related to the scheduled continence routines and identified that staff documented on each of the specific interventions only once during the specific shifts reviewed.

Inspector #638 reviewed resident #001's progress notes and identified a notation created on one of the dates identified by RPN #110, which indicated that the resident continued to call for assistance frequently, even after continence care was provided. The Inspector then reviewed the electronic and paper health care records again, there was no documentation to support that the resident was provided with continence care assistance at any other times throughout the evening shift, as per the plan of care intervention and progress note notation.

During an interview with Inspector #638, PSW #103 indicated that they were required to record, in two difference records, any continence care assistance provided to the resident. The PSW indicated that they had to ensure that they documented the times the resident was provided with continence care.

In an interview with Inspector #638, RPN #110 indicated that direct care staff documented the continence care provided for resident #001 on two difference records. The Inspector reviewed the aforementioned progress note with the RPN, who indicated

that the resident had received frequent continence care. The RPN indicated that staff were supposed to document specific times continence care occurred for the resident because they were trying to ensure that the resident was maintained on a schedule.

The home's policy titled "Personal Support Worker – Position Descriptions – Long Term Care" last revised January 2017, indicated that one of the main duties and responsibilities of the personal support worker was to complete resident records accurately to reflect the resident care provided complying with legislative and home requirements.

During an interview with Inspector #638, the acting Administrator and Co-DOC #105 indicated that direct care staff were supposed to document toileting care and times provided to resident #001 on two different records. The Inspector reviewed the two different records with the acting Administrator and Co-DOC #105, who indicated that the resident would have been provided with continence care during those shifts and they believed staff forgot to document the specific times in which the resident was assisted. [s. 6. (9) 1.]

2. A) Inspector #638 reviewed resident #004's health care records and identified that the resident had a specific continence care routine.

The Inspector reviewed a record for resident #004's specific continence care intervention and identified through the two week review period, that there was no documentation to support the completion of this task for the evening shift on one specific date, for both the day and evening shift on a second date, the day shift on a third date and the evening shift on a fourth date.

Inspector #638 reviewed resident #004's documentation records for the aforementioned dates, and identified that on each date that there was missing documentation related to continence care; nutrition; assistance with activities of daily living; skin integrity; responsive behaviours; pain management and care provided as per care plan.

The Inspector reviewed the progress notes and was unable to identify any notations for any of the aforementioned dates that the resident received the care, refused or was not present in the home during these times.

B) Inspector reviewed resident #005's health care records and identified that the resident was on a continence care routine that was maintained on a specific schedule and as

needed.

The Inspector reviewed the task documentation record for resident #005's continence care intervention and identified in the two week review period that there was no documentation to support the completion of this task on two specific dates for the day and evening shift.

Inspector #638 reviewed resident #005's documentation records for the aforementioned dates and identified that on each date that there was missing documentation related to continence care; nutrition; assistance with activities of daily living; responsive behaviours; skin integrity; mobility; and care provided as per the plan.

The Inspector reviewed the progress notes and was unable to identify any notations for any of the aforementioned dates that the resident received the care, refused or was not present in the home during these times.

C) During the record review the Inspector noted that multiple residents were missing at least one aspect of their required task documentation during the aforementioned dates. Upon reviewing the care records for all the residents, the Inspector noted that on;
-the first date, during the evening shift, 32 out of 128 residents (25 per cent) had missing documentation for the care they received;
-the second date, during the day shift, 31 out of 128 residents (24 per cent) had missing documentation for the care they received;
-the second date, during the evening shift, 36 out of 128 residents (28 per cent) had missing documentation for the care they received;
-the third date, during the day shift, 42 out of 127 residents (33 per cent) had missing documentation for the care they received; and
-the fourth date, during the evening shift, 21 out of 128 residents (16 per cent) had missing documentation for the care they received.

During an interview with Inspector #638, PSW #111 indicated that staff referred to the resident care plan and Kardex for resident specific care information and that the care provided was documented on a record. The Inspector reviewed resident #004's health care records and scheduled tasks and inquired why certain tasks had no documentation. The PSW responded they could not speak for others but that they were expected to complete charting to ensure that all staff were aware of what's going on with the resident, even if the care did not occur.

In an interview with Inspector #638, RPN #110 indicated that direct care staff were aware of resident needs based on the care plan and Kardex and that staff documented the care provided in records. The RPN indicated that in the records they try to ensure none of the tabs were left "pink" (not documented) because it would mean it was late and stated that staff had options to document if the resident refused or was away when the care was due. The RPN indicated that staff were expected to document on care provided based on the plan of care.

During an interview with Inspector #638, the acting Administrator and Co-DOC #105 indicated that PSWs documented the care they provided and they were supposed to document whenever they had the time. The Co-DOC indicated that if documentation was completed later on staff could adjust the time of care on the documentation record to identify when care was completed. The Inspector reviewed resident #004's documentation record for one of the dates, during the evening shift, with the acting Administrator and Co-DOC #105. Upon review, the Inspector inquired if the staff were expected to document on the care completed and they stated "yes" because it was how they identified what care was provided. The Co-DOC indicated that they believed that due to staffing constraints, the staff were pushing documentation aside to ensure that the care was being done and forgetting to document. [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 provision of care laid out in the plan of care is documented, to be implemented voluntarily.

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.