Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 23, 2020	2020_668543_0010	002965-20, 003666-20	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

TIFFANY BOUCHER (543), DAVID SCHAEFER (757)

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): May 27-29, 2020 (offsite) and June 1-4, 2020 (onsite).

The following complaint intakes that were submitted to the Director were inspected during this complaint inspection:

One intake, related to improper care, and
One intake, related to staffing, care plans and cleanliness of the home.

A Critical Incident System inspection #2020_668543_0009, and a Follow-up inspection #2020_668543_0011 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director Of Care (Co-DOC), Staff Educator, Restorative Care Coordinator, Restorative Care Aide, Environmental Services Manager, Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN) and Personal Support Workers (PSW).

The Inspector also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Medication
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident was investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

A complaint was submitted to the Director on a date in 2020, related to unresolved ongoing specific care concerns for resident #001.

The home's policy “Resident Rights, Care and Services - Reporting and Complaints - Concerns and Complaint Process”, last updated May 10, 2017, indicated that the purpose of the policy was to "provide a formal process and resource for initialing and communicating concerns and complaints". The policy further stated that complaints "shall be investigated and resolved, where possible, and a response provided within 10 days of the receipt of the complaint" and "where the complaint alleges harm or risk of harm to one or more residents investigation shall be commenced immediately".

A) Inspector #757 conducted a review of resident #001's electronic records. A progress note by the Restorative Care Coordinator from a specific date in 2019, indicated that the resident had specific concerns related to an assistive device. The progress note further indicated that the resident had been assessed by a member of the inter-disciplinary team, and that a piece for the assistive device had been ordered for the resident.

A progress note by Restorative Care Aide (RCA) #109 dated on a date in 2019, indicated that they had received a verbal complaint related to concerns regarding resident #001

and their assistive device.

Another progress note by RCA #109 from a different date in 2019, indicated they had received another verbal complaint related to concerns regarding resident #001 and their assistive device.

Inspector #543 conducted a record review of the home's complaints documentation. The Inspector was unable to locate any documentation related to these verbal complaints made to the home on two separate dates in 2019.

During an interview with RCA #109, they stated that they discussed any concerns daily, but could not recall if they had done so with regard to these complaints. Inspector #757 conducted an interview with the Restorative Care Coordinator who indicated that there had been no investigation into these complaints.

During an interview with the DOC, they indicated that when the home received a verbal complaint it was required to be documented and an investigation was to be conducted. The DOC stated that staff were required to bring complaints to charge staff who would then bring the concerns up to management. The DOC further indicated that the verbal complaints made on two separate dates in 2019, should have been investigated.

B) Review of resident #001's electronic progress notes identified that on a date in 2020, the resident was noted to be unwell. The note further indicated that a diagnostic test had been collected and placed in the home's area for lab pick-up.

A progress note, identified that Co-DOC #112 had received a verbal complaint related to the diagnostic test. The complainant identified concerns that the results of the test, had not yet been received. The complainant had concern of risk of harm to the resident due to the possibility of complications, which could have been left untreated as the test had not been completed yet. The progress note also identified that the complainant alleged to have had communication concerns when contacting the home regarding the test. The progress note stated the complainant had contacted various staff members regarding the diagnostic test results and did not receive a concrete answer. The progress note made no indication that any investigation was conducted regarding the concerns related to the missing test results, or related to the communication concerns with various staff members.

During an interview conducted with Co-DOC #112, they stated that they had apologized

for the missing results and offered another diagnostic test be initiated. However, at the time of the complaint the resident's symptoms had resolved. The Co-DOC confirmed that no investigation was conducted regarding either of the concerns brought forward by the complainant. [s. 101. (1) 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 every written or verbal complaint made to the licensee or staff member concerning the care of a resident is investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation shall be commenced immediately, to be implemented voluntarily.

WN #2: 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 #001 was reassessed and their plan of care reviewed and revised when their care needs changed.

A complaint was submitted to the Director on a date in 2020, related to ongoing unresolved care concerns for resident #001.

The home's policy "Resident Rights, Care and Services - Plan of Care - Plan of Care (Care Planning)", last updated September 24, 2019, stated that "The plan of care shall be reviewed and revised when the resident's care needs change, the care set out in the plan is no longer necessary; or the care set out in the plan has not been effective".

A record review of resident #001's electronic health records indicated that the resident received a specific piece for their assistive device on a date in 2019.

Inspector #757 reviewed resident #001's current care plan. RPN #108 confirmed with the Inspector that the care plan made no mention of the specific piece for their assistive device or related interventions.

During an interview with RPN #108, they indicated that resident #001 still required the specific piece for their assistive device and that it was implemented and in place on the resident's assistive device. The RPN stated that for resident's requiring specific pieces of equipment, care staff were required to ensure that they were both in place, and properly installed. The RPN indicated that these interventions should have been included in the resident's care plan.

The Inspector conducted an interview with the Restorative Care Coordinator. They indicated that they had not added interventions to the care plan related to resident #001's specific piece for their assistive device, that the addition of the piece to the resident's care constituted a change in their care needs, and that these changes should have been reflected in the resident's care plan.

During an interview with the DOC, they indicated that when changes occur in a resident's care needs, restorative care would often conduct an assessment and implement changes right away. They indicated that when specific equipment was added to a resident's care, staff would be expected to ensure that the equipment was in place and that it was properly installed. The DOC stated that the care plan should have been updated to include these interventions. [s. 6. (10) (b)]

Issued on this 24th day of June, 2020

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

Original report signed by the inspector.