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
Dec 30, 2021	2021_805638_0023	011890-21, 011961-21, 017831-21, 018257-21, 018260-21	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

RYAN GOODMURPHY (638), STEVEN NACCARATO (744), TIFFANY BOUCHER (543)

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): December 6 - 10, 2021.

The following intakes were inspected upon during this Critical Incident System inspection;
-One log related to a fall resulting in an injury;
-One log related to an unwitnessed fall resulting in an injury;
-One log related to an injury of an unknown cause;
-One log related to a fall resulting in an injury; and
-One log related to staff to resident neglect.

Complaint inspection #2021_805638_0024 and Follow Up inspection #2021_805638_0025 were conducted concurrently with this Critical Incident System 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 Educators, Food Service Manager, Restorative Care Coordinator, Regional Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping, residents and their families.

The Inspector(s) also conducted daily tours of resident care areas, reviewed relevant health care records, investigation notes, policies and procedures, observed staff to resident interactions as well as the provision of care to residents and services within the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident had their fall intervention in place as specified within their plan of care.

The resident's plan of care identified they were to have a fall intervention implemented. The resident sustained a fall resulting in an injury. Staff identified that the fall intervention was not in place at the time of the resident's fall. During an observation of the resident, the Inspector noted that the fall intervention was not implemented. The DOC identified that staff were to ensure that interventions in the resident's plan of care were implemented.

Failure of staff to ensure that the resident's fall intervention was implemented placed the resident at a greater risk of falls resulting in injury.

Sources: The resident's plan of care, progress notes; Inspector's observations; and interviews with the DOC and other staff. [s. 6. (7)]

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 resident and any other resident has their required fall interventions implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident fell, that the resident had a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident sustained a fall. There was no record identifying that the resident had a post fall assessment completed for the fall. The home's "Falls Prevention and Management-Program" identified that registered staff would ensure that when a resident had fallen, they received a post fall assessment.

The Co-DOC and a RPN confirmed a post fall assessment must be completed for all falls and that there was no post fall assessment completed for the resident's fall.

Sources: CIS report, the resident’s progress notes, “Falls Prevention and Management-Program”, interviews with the Co-Director of Care and other staff. [s. 49. (2)]

Issued on this 31st day of December, 2021

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

Original report signed by the inspector.