Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: October 12, 2022	
Inspection Number: 2022-1353-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Valley East Long Term Care Centre Inc.	
Long Term Care Home and City: Elizabeth Centre, Val Caron	
Lead Inspector Ryan Goodmurphy (638)	**Inspector Digital Signature** Ryan C Goodmurphy Digitally signed by Ryan C Goodmurphy Date: 2022.10.20 13:18:41 -04'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 20-23, 2022, and September 26, 2022.

The following intake(s) were inspected:

- One intake which was a complaint related to resident care concerns.
- One intake which was a complaint related to hot temperatures.
- One intake which was a SAO initiated intake related to hot temperatures.
- One intake which was a complaint related to hot temperatures, infection prevention and control practices, maintenance services and resident care concerns.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Skin and Wound Prevention and Management
Falls Prevention and Management
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 26

The licensee has failed to ensure they complied with manufacturers' instructions when using a device to check air temperatures related to the requirements laid out under section 24 of the Ontario Regulation 246/22.

The Inspector observed staff demonstrate how they checked air temperatures. A customer support member from the manufacturer of the temperature checking device identified that the device was being used improperly from its intended purpose.

On September 23, 2022, the Administrator followed up with the Inspector to demonstrate the newly acquired device to measure air temperature, which was implemented once it was obtained.

Sources: The device's guide; Inspector's observations; interviews with the manufacturer's customer support, the Administrator and other staff.

Date Remedy Implemented: September 23, 2022

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan was provided to the resident.

A resident required a specific fall management intervention. The resident sustained two falls and was identified as not having had their specific fall intervention applied at the time of the incidents. The Inspector observed the resident on two separate dates and identified that the fall intervention was not applied.

The Acting DOC identified that direct care staff have access to resident specific care plans and that it was their responsibility to ensure that interventions were reviewed and implemented. The lack of fall intervention placed the resident at an increased risk of falls.

Sources: The resident's health care records; progress notes; care plan; the home's policy titled "LTC Falls Prevention and Management - Program Version: 9" last revised August 15, 2022; resident observations; and interviews with the Acting DOC and other staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was updated when their care needs changed.

A resident's mobility aid was changed on a specific date. At the time of inspection, the resident's plan of care outlined that they were to be encouraged to use the previous mobility aid for ambulation. The Inspector observed the resident using the newly implemented mobility aid and noted the previously used mobility aid at their bedside. The Restorative Care Coordinator identified that the resident was provided with a new mobility aid on a specific date and that this was their primary mobility aid. Upon reviewing the plan of care the Restorative Care Coordinator identified that this change should have been updated and included in the plan of care.

Staff failed to update the resident's plan of care when their care needs changed, which placed the resident at an increased risk of falls, if the incorrect mobility aid was provided to the resident.

Sources: The resident's health care records; progress notes; care plan; the home's policy titled "LTC Falls Prevention and Management - Program Version: 9" last revised August 15, 2022; resident observations; and interviews with the Restorative Care Coordinator and other staff.

WRITTEN NOTIFICATION: Air Temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that air temperatures to be measured in section 24, subsection (2) were measured and documented at least once every morning, once every afternoon between 12p.m. and 5p.m. and once every evening or night.

The Inspector reviewed the home's temperature tracking records and identified a gap in the records for all four home areas. A staff member identified that their role was to check temperatures within the home, however, they identified that there was a period of about a week and a half where the checks were not being done.

The Administrator identified that the staff had been directed to resume temperature checks on a specific date to ensure it was being completed. Staff failure to monitor temperatures within the home placed the residents at risk of being exposed to low or high temperatures.

Sources: Daily Air Quality Tracking Form; and interviews with the Administrator and other staff.