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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965
northdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 24, 2023

Inspection Number: 2022-1353-0003

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	**Inspector Digital Signature**
Steven Naccarato (744)	Steven C Naccarato Digitally signed by Steven C Naccarato Date: 2023.02.02 08:47:50 -05'00'

Additional Inspector(s)
Jennifer Lauricella (542)
Chad Camps (609)
Eva Namysl (000696) was present during this inspection.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 12-16, 19-22, 2022. Additional off-site activities were conducted on January 3, 2023.

The following intake(s) were inspected:

- Three intakes were related to complaints regarding resident care.
- One intake was related to a fall of a resident with significant injury.
- One intake was related to a medication incident causing an adverse reaction.
- One intake was related to resident neglect.
- One intake was related to resident abuse.
- One intake was related to resident care.

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

Food, Nutrition and Hydration
Responsive Behaviours
Infection Prevention and Control
Medication Management
Falls Prevention and Management
Skin and Wound Prevention and Management

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. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented related to hand hygiene.

Rationale and summary

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, the home's IPAC program must include support for residents to perform hand hygiene prior to receiving meals.

During a meal service observation, the inspectors did not observe any residents being supported with hand hygiene prior to receiving their meals. The next day, the inspectors observed staff assisting all residents with hand hygiene prior to receiving their meals.

Sources: Observations of meal services; Home's policy titled "LTC Hand Hygiene Program", last review date: August 16, 2022; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022; Interviews with the IPAC Lead and other staff. [744]

Date Remedy Implemented: December 13, 2022.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (b)

1) The licensee has failed to ensure that a resident's strategies to respond to their responsive behaviours were implemented.

Rationale and Summary

A resident's plan of care indicated that if the resident displayed a certain responsive bahaviour, staff were to implement a specific strategy.

A staff member did not implement the specific strategy required to respond to the resident's responsive behaviour.

The staff's failure to implement the specific strategy in response to the resident's responsive behaviour, caused moderate harm to the resident.

Sources: The Critical Incident (CI) report, the home's internal investigation notes, A letter of discipline, the home's policy titled "LTC Plan of Care (Care Planning)" last revised June 3, 2022, interviews with a Registered Nurse (RN) and the Acting Director of Care (DOC). [609]

2) The licensee has failed to ensure that a resident's strategies for responding to their responsive behaviours were implemented.

Rationale and Summary

A resident required a specific intervention to ensure their safety; however, that intervention was not implemented.

The home's failure to ensure that the resident had their required intervention in place caused moderate risk to the resident.

Sources: Observations of the resident, the resident's health care records, the home's policy titled "LTC Plan of Care (Care Planning)" version two, last revised June 3, 2022, interviews with a Registered Practical Nurse and a Co-DOC. [609]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that a resident received immediate treatment and interventions for their skin breakdown to reduce or relieve pain, promote healing, and prevent infection.

Rationale and summary

A registered staff member was notified of skin breakdown concerning a resident; however, there was no indication of immediate treatment or interventions provided to the resident.

There was moderate risk to the resident for not receiving immediate treatment and interventions for their skin breakdown.

Sources: The resident's electronic health records; the home's policy titled "Skin and Wound Care-Program" Last review date: August 4, 2022; Interviews with the Interim Director of Care and other staff. [744]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident, who had altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from the hospital.

Rationale and Summary

A resident was sent to the hospital and returned to the home the same day. There was no record of a skin assessment by staff upon the resident's return from the hospital.

There was low risk to the resident for not receiving a skin assessment by a member of the registered staff upon the resident's return from the hospital.

Sources: The resident's electronic health records; the home's policy titled "Skin and Wound Care- Program" Last review date: August 4, 2022; Interviews with the Interim Director of Care and other staff. [744]

WRITTEN NOTIFICATION: Nutrition and Hydration

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 74 (2) (e) (i)
The licensee has failed to comply with the system to measure and record a resident's weight.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a resident weight monitoring system and must be complied with.

Specifically, staff did not comply with the policy "LTC, Monthly Weights and Weight Variance Report", dated February 14, 2022, which was included in the licensee's Nutrition and Hydration Program.

The home failed to complete a re-weigh for a resident as per the home's policy.

The home's failure to complete a re-weigh did not impact the resident's health and safety.

Sources: Complaint intake; a resident's health record; home's policy, "LTC, Monthly Weights and Weight Variance Report" and interview with the acting DOC. [542]

WRITTEN NOTIFICATION: Directives by Minister

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applied to the home was carried out.

Rationale and Summary

a) The Minister's Directive required that a specific medical incident was to be reported to the home's DOC.

A resident's specific medical incident was not reported to the DOC as required by the Minister's Directive.

Registered staff's failure to report the specific medical incident to the DOC presented minimal risk to the resident.

Sources: Minister's Directives, a CI report, the home's internal investigation notes, the resident's health care records, the home's policies, interviews with an RN, a Clinical Pharmacist and the Acting DOC.

b) The Minister's Directive required that the Director was informed no later than one business day after the occurrence of an incident where a resident who experienced a specific medical incident resulted in the resident being taken to a hospital.

A resident experienced a specific medical incident that resulted in hospitalization; however, the Director was not notified within one business day as required in the Minister's Directive.

The home's failure to inform the Director of a resident's specific medical incident no later than one business day caused no harm to the resident.

Sources: Minister's Directives, the CI report, the home's internal investigation notes and an interview with the Acting DOC. [609]

WRITTEN NOTIFICATION: Documentation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the care provided to a resident was documented.

Rationale and Summary

a) A staff member documented care that the resident did not receive.

b) A staff member documented care that was not accurate.

The home's failure to document the provision of care as specified in a resident's plan of care presented minimal risk to the resident.

Sources: Observations of a resident, the home's instructional guides, interviews with an RPN and the Administrator. [609]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Standard issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary

The Infection Prevention and Control (IPAC) Standard required the licensee ensure that Routine Practices were implemented.

A staff member did not implement Routine Practice as per the IPAC Standard.

The home's failure to ensure that the IPAC Standard was implemented caused actual risk of infection to a resident.

Sources: The CI report, the home's internal investigation notes, a letter of discipline, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes dated April 2022, Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings, revision date: November 2016, interviews with an RN and a Clinical Pharmacist. [609]