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

Original Public Report

Report Issue Date: March 28, 2023
Inspection Number: 2023-1353-0005
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**
Lisa Moore (613)	Lisa K Moore Digitally signed by Lisa K Moore Date: 2023.03.31 11:03:57 -04'00'

Additional Inspector(s)
N/A

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-15, 2023.

The following intake(s) were completed during this inspection:

- Intake related to care concerns.
- Intakes related to neglect.
- Intakes related to a missing controlled substance.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that two residents were protected from neglect by a PSW.

Neglect is defined within Ontario Regulation 246/22 as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rational and Summary: A resident was found unattended by a Personal Support Worker (PSW) attached to a specific type of equipment in a residential area. The investigation file identified that the resident had been in the area for an extended period of time before being located by staff.

The Administrator (ADM) indicated that the PSW did not complete visual checks at specific times on the resident and neglected to provide the required care to the resident, during this time, as per their care plan.

A Regional Manager (RM) stated it was an expectation that PSWs complete a round at the start of their shift to ensure all residents were safe and that their needs were met.

The failure of the PSW neglecting a resident resulted in moderate impact and risk, as they were in the residential area for an extended period of time, before being located by staff.

Sources: CIS report; internal investigation file; written statement by the PSW; Nursing Rounds Routine (PSW); LTC Abuse-Zero Tolerance Policy; and interview with ADM and a RM. [613]

2. **Rational and Summary**: Another resident was found by a PSW, lying in their bed from the previous shift.

The ADM verified that a PSW did not complete visual checks at specific times on the resident during their shift and neglected to provide the required care to the resident as per their care plan.

The failure of the PSW neglecting the resident resulted in moderate impact and risk, as their care needs were unmet for an unknown amount of time.

Sources: CIS report; internal investigation file; Nursing Rounds (PSW); LTC Abuse-Zero Tolerance Policy; and interview with ADM and a RM. [613]

WRITTEN NOTIFICATION: Reporting of Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee failed to ensure that a documented record was kept in the home for a verbal complaint made to the licensee concerning the care of a resident, that included a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Rational and Summary: **Rational and Summary**: A complaint was received by the Director identifying concerns that a resident's family were not notified of the resident's care orders.

The ADM and DOC were unable to provide a documented record of the complaint.

There was no risk or impact to the resident.

Sources: Interview with Complainant, ADM, RM, and DOC. [613]

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