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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 14, 2023
Original Report Issue Date: July 10, 2023
Inspection Number: 2023-1353-0007 (A1)
Inspection Type: Critical Incident System
Licensee: Valley East Long Term Care Centre Inc.
Long Term Care Home and City: Elizabeth Centre,Val Caron

Amended By	**Inspector who Amended Digital Signature**
Justin McAuliffe (000698)	Justin Christopher Mcauliffe Digitally signed by Justin Christopher Mcauliffe Date: 2023.07.14 14:51:25 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This public inspection report has been revised to reflect the correct licensee report issued date on the licensee report to be July 10th, 2023. The inspection 2023-1353-0007 was completed on June 19, 2023, to June 21st, 2023.

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Licensee: Valley East Long Term Care Centre Inc.	
Long Term Care Home and City: Elizabeth Centre, Val Caron	
Lead Inspector Justin McAuliffe (000698)	**Additional Inspector(s)** Ryan Goodmurphy (638)
Amended By Justin McAuliffe (000698)	**Inspector who Amended Digital Signature** Justin Christopher Mcauliffe Digitally signed by Justin Christopher Mcauliffe Date: 2023.07.14 14:51:00 -04'00'

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19-21, 2023.

The following intake(s) were inspected:
- One intake related to a missing controlled substance; and
- One intake related to a fall that resulted in an injury

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

Medication Management
Infection Prevention and Control
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Medical Cannabis

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 143 (1)

The licensee failed to ensure that the home complied with the requirements set forth in the homes medical cannabis policy, when a resident had medical cannabis prescribed.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure that the homes medical cannabis policy is complied with.

Specifically, the home failed to ensure that the medical cannabis policy was complied with for the management of prescribed medical cannabis.

Rationale and Summary
Medical cannabis was prescribed for a resident. The staff did not adhere to the home's medical cannabis policy.

In several interviews, it was noted that the medical cannabis policy should have been followed but was not. The failure to ensure that the medical cannabis policy was followed by staff resulted in moderate risk to the resident.

Sources: The resident's healthcare record; the home’s policy titled “LTC Medical Cannabis” Version: 7 last revised 13/05/2022; Interviews with the administrator, regional manager, director of care and other staff. [000698]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to ensure that the home complied with the requirements set forth in the homes fall prevention and management program, when a resident had a fall.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure that the home's falls prevention and management program is complied with.

Specifically, registered staff did not comply with the home's falls prevention and management program; which required the completion of a specified assessment tool after a resident fell.

Rationale and Summary
A resident had a fall which required the completion of a specified assessment tool. The specified assessment tool was not completed in its entirety.

The director of care identified that registered staff should have completed the specified assessment tool. The failure to monitor the resident's status after the fall, resulted in moderate risk to the resident.

Sources: The resident's health care records; the home's policy titled "LTC Falls Prevention and Management - Program" Version: 10 last revised 10/04/2023; interviews with the administrator, director of care and other staff. [638]

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to ensure that the director was informed of an incident that caused an injury to a resident for which they were taken to hospital and resulted in a significant change in the resident's health condition, within the allotted timeframe.

Rationale and Summary
The resident sustained a fall, and was sent to hospital. The resident returned from hospital with a significant change in status. The incident was reported to the director several days after the change of status was identified.

The failure to report an incident that caused an injury to the resident for which they were taken to hospital and resulted in a significant change in the resident's health condition within the allotted timeframe, had no impact or risk to the resident.

Sources: The resident's health care records; and an interview with the administrator. [638]