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: November 9, 2023	
Inspection Number: 2023-1353-0008	
Inspection Type: Complaint Critical Incident	
Licensee: Valley East Long Term Care Centre Inc.	
Long Term Care Home and City: Elizabeth Centre, Val Caron	
Lead Inspector Lauren Tenhunen (196)	**Inspector Digital Signature** Lauren Tenhunen Digitally signed by Lauren Tenhunen Date: 2023.11.16 12:54:55 -05'00'
Additional Inspector(s) Eva Namysl (000696)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 23-27, 2023.

The following intakes were inspected:

- Three intakes related to complaints regarding resident care;
- Two intakes related to complaints regarding temperatures in the home; and
- One intake related to a Critical Incident for a Disease Outbreak.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The Director of Care (DOC), who had reasonable grounds to suspect improper or incompetent treatment or care of a resident, which resulted in harm to the resident, failed to immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
A Personal Support Worker (PSW) was providing assistance to a resident. Another PSW came to assist and later noticed an injury to the resident. Both PSW's reported their recollection of the incident to the registered staff and the second PSW submitted a hand-written note to the Director of Care (DOC). The DOC wrote a progress note after the incident indicating that the PSW was providing a specific type of assistance to the resident without the use of an assistive device which resulted in an injury to the resident. Despite conducting an internal investigation regarding the incident, the DOC did not submit a critical incident report to the Director.

Sources: A residents progress notes; Home's internal investigation notes; Interviews with a PSW and the DOC; and Home's policy: Mandatory Reporting Policy. [000696]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

A complaint was received by the Director regarding staff assistance with an activity of daily living (ADL) for a resident. Specifically, staff not using a specific assistive device to aid in an activity of daily living.

A PSW was observed to provide assistance to a resident with an ADL without the use of a specific assistive device. The Physiotherapy Assistant (PTA) was observed assisting a different resident without the use of the assistive device.

A Registered Practical Nurse (RPN) indicated that some staff members use a different method of assisting the same particular resident with an ADL. A Physiotherapist (PT) reported that a specific assistive device should be used for this resident as they required a type of assistance with an ADL.

The DOC reported that staff using a different method of assisting a resident with an ADL was discouraged; that the specific assistive devices were available; and that the Restorative Care Lead would be providing further staff education regarding this.

Sources: Interviews with the complainant; a PSW, PTA, PT, RPN and the DOC; Review of the transfer assessment and current care plan for a resident; Homes' policy titled, "Resident Transfers, Lifts and Positioning Guidelines" Version 7, page 2 of 9. [196]