Ontario

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

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: April 16, 2024	
Inspection Number: 2024-1353-0001	
Inspection Type: Critical Incident	
Licensee: Valley East Long Term Care Centre Inc.	
Long Term Care Home and City: Elizabeth Centre, Val Caron	
Lead Inspector Jennifer Nicholls (691)	**Inspector Digital Signature**
Additional Inspector(s) Karen Hill (704609) Barbara Humenjuk (000741) Training Specialist Michelle Berardi was also present for this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22-26, 2024.
The inspection occurred offsite on the following date(s): January 29-31, 2024.

The following intake(s) were inspected:

· One Intake related to allegation of neglect of a resident.

· Seven Intakes related to improper/incompetent care of a resident.

· One Intake related to an Outbreak.

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The Licensee has failed to ensure that the plan of care was revised when the resident's care needs changed, and the care set out in the plan was no longer necessary.

Rationale and Summary
During an observation on a specified date, a few residents were noted to be on isolation precautions. During a subsequent observation on a specified date, it was noted that the signage indicating the residents' required isolation precautions had been removed.

A review of the residents' electronic health records found no documentation indicating that either resident had been removed from isolation precautions.

A follow up review of the residents' profiles on a specified date revealed the required isolation precautions had been removed from both resident profiles.

The failure to revise the plan of care when the residents' care needs changed, had minimal impact to the residents.

Sources: Observations of residents rooms; record review of residents electronic health records, including progress notes and IPC in PCC, the home's policy, titled "LTC Plan of Care (Care Planning), last reviewed and revised on March 6, 2022; and an interview with the IPAC Lead.

[000741]

Date Remedy Implemented: January 26, 2024

WRITTEN NOTIFICATION: Plan of Care - Falls Prevention

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

Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that a resident's specified interventions in their plan of care were provided to the resident as specified in the plan.

Rationale and Summary
During shift change on a specified date, a Personal Support Worker (PSW) entered a resident's room and noted that the specified interventions were not in place.

A review of the resident's electronic health record indicated that specified interventions were to be in place as per their plan of care.

As a result of the specified interventions not being in place the resident was at risk of injury.

Sources: Record review of a resident's electronic health records, including progress notes and care plan, Director of Care email, and interviews with a PSW and a Registered Practical Nurse (RPN).

[000741]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (a)
Infection prevention and control program
s. 23 (2) The infection prevention and control program must include,

(a) evidence-based policies and procedures;

The licensee has failed to comply with the home's infection prevention and control program related to vaccinations for specified residents.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that evidence-based policies and procedures were included in the IPAC program and ensure that they were complied with.

Specifically, staff did not comply with the licensee's policy, titled "LTC Vaccination Consent", version 3, with a revision date of October 8, 2021.

Rationale and Summary
The licensee's "Vaccination Consent" policy stated that prior to administering vaccines, staff were to ensure consent was obtained and the consent discussion was documented on the licensee's "Vaccination Consent Form." Staff were to ensure that the consent form was signed by the resident or the Substitute Decision Maker (SDM) and was kept in the resident's file.

Two residents received vaccinations, but the home was unable to locate completed consent forms for the vaccines that had been administered.

The IPAC Lead and the Administrator confirmed that the vaccination consent policy was not followed. That consent was required every year, and was to be documented on the licensee vaccination consent form, which was to be used to verify consent prior to administering any vaccine.

When the licensee failed to ensure that the policy was followed related to vaccination consent, there was actual risk that both residents would receive a

vaccination without consent.

Sources: The residents clinical health records, and the licensee's policy, titled "LTC Vaccination Consent", version 3, revised October 8, 2021; and interviews with RN's, the IPAC Lead, and the Administrator.

[704609]

WRITTEN NOTIFICATION: Late reporting

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The Licensee has failed to immediately report an allegation of neglect towards a resident to the Director.

Rationale and Summary
A Critical Incident (CI) Report was submitted to the Director via after hours report on a specified date, for an allegation of neglect towards a resident which occurred on specified date.

In an interview with the Administrator, they confirmed that the did not immediately inform the home's management of the alleged neglect, which resulted in the incident being reported late.

The failure to immediately report the alleged neglect to the Director placed the resident at minimal risk.

Sources: Record review of a resident's electronic health records, including progress notes and assessments, the home's "Zero Tolerance Policy for Abuse and Neglect", and CI Report; and interviews with a PSW, an RPN, and the Administrator.

[000741]

WRITTEN NOTIFICATION: IPAC Self Audits

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that every operational or policy directive that applies to the long-term care home was carried out.

Rationale and Summary
The Minister's Directive, titled "Minister's Directive: COVID-19 response measures for long-term care homes" effective August 30, 2022, stated that homes were required to conduct IPAC self-audits in accordance with the COVID-19 Guidance Document for Long-Term Care (LTC) Homes in Ontario, at a minimum once a week while in outbreak. The home was in outbreak for a specified period of time.

The IPAC lead identified that there were no self audits conducted during the outbreak period.

The risk to the residents related to incomplete self-assessments audits were low.

Sources: Record review of the home's IPAC Policy, titled "LTC Infection Prevention and Control Program", revised November 13, 2023, and the Minister's Directive, titled "Public Health Ontario COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes", effective date August 30, 2022; and an interview with the IPAC Lead.

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WRITTEN NOTIFICATION: Continence Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee failed to ensure that a resident's individualized continence care plan was implemented.

Rationale and Summary
During a specified shift, a resident was to not have received care as per their care plan.

The Administrator indicated that the PSW did not provide the resident with the care they required.

The lack of care provided placed the resident at moderate risk.

Sources: Record review of a resident's electronic health records including progress notes and care plan, and PSW communication on a specified date; and interviews with a PSW and the Administrator.

[000741]

WRITTEN NOTIFICATION: Nutritional Care and Hydration programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to ensure that interventions were implemented to mitigate and manage nutritional risks related to a resident with allergies.

Rationale and Summary
A critical incident (CI) was submitted to the Director regarding a resident's allergic reaction after consuming a specified food item.

A Resident's admission notes, plan of care, and physician order sheets all indicated that the resident had specified allergies.

The Culinary Manager stated that they were responsible for ordering items for food production at the home and was not made aware a food item contained a specific ingredient.

Failure to ensure that interventions to mitigate and manage risks related to the resident nutritional care needs, specific to allergies, may have caused significant harm to the resident.

Sources: Critical Incident (CI) ; a resident's progress notes, care plan, and admission notes; homes Master Diet List (MDL); Sysco Systems nutritional fact sheet; licensee policies titled "LTC Meal Service" and "Food production", and interviews with the Culinary Manager and other staff.

[691]

WRITTEN NOTIFICATION: Symptom Monitoring

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

1) The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in a resident, were monitored.

Rationale and Summary
A resident was found to have signs and symptoms of an infection and was placed on additional precautions for further days.

A review of the resident's clinical health record revealed that infection monitoring assessments, including vital signs, were not completed on each shift during the isolation period.

An RPN and the IPAC Lead confirmed that symptom surveillance was required to be completed and documented in the resident's clinical health record, on every shift.

Failure to complete symptomatic infection monitoring for a resident, on every shift, put the resident at risk of the infection progressing undetected and developing complications.

Sources: Observations of a resident ; review of a resident’s clinical health record, and the licensee's policy, titled "IPAC Surveillance Policy", last reviewed July 11,

2023, and interviews with an RPN and the IPAC Lead.

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2) The licensee has failed to ensure that symptoms indicating the presence of infection in a resident were recorded.

Rationale and Summary
On a specified date, a resident was noted to have symptoms of infection and was placed on isolation precaution which was confirmed in their electronic health record that isolation precautions were required.

A further review of a resident's electronic progress notes and assessments revealed that symptoms indicating the presence of infection were not recorded each shift during the specified time period .

The failure to ensure that symptoms indicating the presence of infection in a resident were recorded placed the resident at minimal risk.

Sources: Observation of a residents room on specified date; record review of a resident's electronic health files including progress noted, assessments and daily infection monitoring notes, the home's IPAC policies, titled "LTC Infection Prevention and Control Program", revised November 13, 2023, and "LTC Infection Prevention and Control Surveillance Policy", revised November 8, 2023; and an interview with IPAC Lead.

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WRITTEN NOTIFICATION: Administration of Drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that medications administered to the specific residents were prescribed for the residents.

Rationale and Summary
On a specified date two residents received medications that were not prescribed for them.

The licensee's medication administration policy stated that when administering medications in the home, registered staff were to apply the rights of medication administration, which included the right resident, verified by two resident identifiers.

The Administrator confirmed that both residents received medications not prescribed for them. They confirmed that resident verification should have been used to ensure that it was the correct resident, in accordance with the rights of medication administration, before administering the medications to each resident.

There was minimal impact to both residents when the RPN administered medications that were not prescribed for them.

Sources: Review of two residents clinical health records, the home's investigation notes, the licensee's policy, titled "LTC Administration of Medications including PRN Medications", last reviewed October 23, 2023; interviews with both residents; and an

RPN, an RN, and the Administrator.

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WRITTEN NOTIFICATION: Medication

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The Licensee has failed to ensure that a specified medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A review of a resident's electronic medication administration record (eMAR) indicated they were prescribed a specified medication during an outbreak. The order specified that the medication was to be discontinued as per the directions.

A further review of a resident's eMAR indicated that they had received a specified medication on multiple occasions after it was to be discontinued.

The impact to the resident was minimal and risk was low.

Sources: Record review of a resident's electronic health record including progress note, eMAR and paper chart; and an interview with the IPAC Lead.

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COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Educate specified staff on the proper use of personal protective equipment (PPE) as it relates to when to use PPE and the proper donning/doffing procedures; and maintain documentation of the training.
2. Re-educate registered staff on the home's process for posting and removing enhanced precaution signage. Documentation of this education must be maintained.
3. Develop and implement an auditing process to ensure that: staff are utilizing the appropriate PPE for the situation; proper donning and doffing procedures are adhered to; and that the appropriate enhanced precaution signage is posted. Audits must be completed weekly for a minimum of four weeks. Documentation of the audits and any corrective action that was implemented as the result of the audits, must be maintained.

Grounds
1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Specifically related to additional personal protective equipment (PPE).

Rationale and Summary
According to the IPAC Standard for Long Term Care Homes (LTCH)s, revised September 2023, section 9.1 (f), the licensee was to ensure that additional PPE requirements included appropriate selection, application, removal, and disposal.

Signage for contact and droplet precautions, and donning and doffing of PPE, were observed at the entrance to a resident's room.

A PSW was observed in the resident's room without gloves on.

An RPN was observed entering and exiting the resident room without donning and doffing their PPE in the correct sequence, or performing hand hygiene when required.

The licensee's policy, titled "LTC Routine Precautions", last revised November 8, 2023, indicated that staff were to follow the signage posted in the home and outlined the sequence required for donning and doffing of PPE.

Failure to ensure that staff correctly selected, donned, and doffed their PPE when entering and exiting a resident's room who was under contact and droplet precautions, may have put other residents in the home at risk of contracting a health care-associated infection.

Sources: Observations done on a specified date; review of a residents clinical health record; review of the licensee's policies, titled "LTC Routine Precautions", last revised November 8, 2023, "LTC Additional Precautions", revised November 8, 2023, and "Infection Prevention and Control Program", last revised November 13, 2023, and Public Health Ontario, "Routine Practices and Additional Precautions in All Health Care Settings", 4th edition, April 2014; and interviews with the IPAC Lead.

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2) On a specified date, a PSW was observed to exit a resident room that had enhanced precaution signage without correctly doffing their PPE.

In an interview with the IPAC lead identified that the correct process for doffing was not followed.

There was minimal impact and moderate risk at the time of inspection as the home was in consultation with Public Health regarding a possible outbreak on home area two.

Sources: Observation on a specified home area on a specific date; record review of the home's policy, titled "LTC Routine Precautions", last revised November 8, 2023; and Additional Requirement 9.1 (a) of the IPAC Standard for Long Term Care (LTC) Homes, revised September 2023; and an interview with the IPAC Lead.

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3) The licensee has failed to implement any standard and protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
According to Additional Requirement 9.1 of the IPAC standard for Long-Term Care Homes, revised September 2023, the licensee was to ensure point-of-care signage indicating that enhanced IPAC control measures were in place.

During observations of the home conducted on multiple days, there were isolation carts outside of a few of resident's rooms; however, no signage was present to indicate the type of additional precautions required.

A review of resident electronic health records determined that each resident was on different specified isolation precautions.

The failure to ensure the placement of enhanced precaution signage posed minimal risk to residents.

Sources: General IPAC observations on multiple days; record review of resident's electronic health records, including progress notes and assessments, the home's policies, titled "LTC Additional Precautions" last revised November 8, 2023, "Prevention and Management of Respiratory Outbreaks", reviewed October 2023, and Provincial Infectious Diseases Advisory Committee (PIDAC): PHO Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012; and interviews with a PSW's, RPN's, an RN, and the IPAC Lead.

[000741]

This order must be complied with by May 28, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.