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
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Original Public Report

Report Issue Date: September 24, 2024
Inspection Number: 2024-1353-0002
Inspection Type: Critical Incident Follow up
Licensee: Valley East Long Term Care Centre Inc.
Long Term Care Home and City: Elizabeth Centre, Val Caron

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26-30, 2024

The following intake(s) were inspected:

- Four intakes, related to allegations of resident abuse and neglect by staff;
- Intake, related to an unexpected death of a resident; and,
- Intake, related to Follow-up for compliance order (CO) #001 from Inspection 2024-1353-0001, for Infection Prevention and Control concerns.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1353-0001 related to O. Reg. 246/22, s. 102 (2) (b)

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 has failed to ensure that a resident was provided with the assistance level they required, as indicated in the resident's plan of care.

Rationale / Summary
A Personal Support Worker (PSW) had been assisting a resident with a specific activity of daily living (ADL), and prior to them completing the task, they went to provide assistance to another resident. During that time, the resident had continued the specific ADL themselves, which resulted in an incident involving the resident.

There was an impact and risk at time of incident to the resident, related to the PSW not providing the required assistance level.

Sources: Interviews with direct care and registered staff; review of a resident's health care records; Long-Term Care Homes (LTCH) investigation notes.

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that two residents were protected from abuse and neglect by staff.

Rationale and Summary
1. A PSW reported to the Registered Nurse (RN) that they had witnessed another PSW being inappropriate while providing care to a resident. The PSW and RN both indicated that the resident was demonstrating anxiety and expressing fear after the care had been completed.

The LTCHs internal investigation notes and the Administrator identified that the incident of abuse towards the resident by the PSW had been substantiated, and that the resident had been upset due to the incident.

There was an impact to the resident, as they had become upset and was showing signs of anxiety and distress when the alleged PSW was in their vicinity.

Sources: CI report; a resident's health care records; the LTCHs internal investigation notes; staffs personnel file; the home's policy titled, "LTC-Abuse-Zero-Tolerance Policy for resident abuse and neglect", last revised August 25, 2024; and interviews with direct care and registered staff, and the Administrator.

Rationale and Summary
2. (a) Another resident had been found by direct care staff and it was evident that they had not received care by staff. The resident identified that a PSW had had not assisted them with the care that they required and spoke to them inappropriately.

Direct care staff and registered staff identified that the resident had been upset when they had found them, stating that they were reporting the PSW for neglect.

The Administrator identified that the allegation of neglect towards the resident by the PSW had been substantiated and was managed through the home's disciplinary process. They indicated that the incident had resulted in the resident being upset and uncomfortable at the time.

There was an impact to the resident because of being neglected by the PSW.

Rationale and Summary
(b) A resident's substitute decision maker (SDM) brought forward an allegation of abuse towards the resident by a specified PSW.

The resident indicated that the incident had caused them to be upset and mistrust the staff member. The Administrator confirmed the allegation of abuse towards the resident was founded.

There was an impact to the resident resulting from the abuse they incurred.

Sources: CI reports; a resident's health care records; the home's internal investigation notes; the home's policy titled, "LTC Abuse-Zero-Tolerance Policy for resident abuse and neglect, version 6, last revised August 25, 2024"; and interviews with the resident, direct care staff, registered staff, and the Administrator.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 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 ensure that an allegation of abuse towards a resident by staff, was reported to the Director immediately.

Rationale and Summary
A resident was not provided with the care that they required. The RN who responded to the allegation had not reported the allegation to senior management immediately; the CI report was submitted to the Director three days after the incident occurred.

Registered staff and the Administrator identified that all allegations of abuse towards a resident, by anyone, were to be immediately reported to the Director, and confirmed the allegation involving the resident was not.

There was low risk to the residents for not immediately reporting the allegations to the Director.

Sources: CI report; a resident's health care records; the LTCHs internal investigation;

the LTCHs policy, titled "LTC-Abuse-Zero-Tolerance Policy for resident abuse and neglect", last revised August 25, 2024; and interviews with direct care and registered staff, and the Administrator.

WRITTEN NOTIFICATION: Qualifications of personal support workers

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 52 (1) (b)
Qualifications of personal support workers
s. 52 (1) Every licensee of a long-term care home shall ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 246 / 22, s. 52 (1).

The licensee has failed to ensure that a staff member, who had been hired as a PSW had provided proof of graduation issued by the education provider.

A staff member had been hired by the LTCH, and a review of their personnel file did not contain a PSW certificate indicating they had completed an approved PSW program.

Sources: A staff member's personnel file; the home's internal investigation notes; and interviews with direct care and registered staff, the staffing coordinator, and the Administrator.