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

Public Report

Report Issue Date: December 18, 2024

Inspection Number: 2024-1353-0003

Inspection Type:
Complaint
Critical Incident

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): December 9-13, and 16-18, 2024.
The inspection occurred offsite on the following date(s): December 13, 2024.

The following intake(s) were completed:
· One intake related to neglect of a resident by a staff member;
· Two intakes related to COVID-19 outbreaks in the home;
· One intake related to resident physical abuse by staff; and
· One intake related to a complaint related to infection prevention and control in the home.

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

Resident Care and Support Services
Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #001 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 a person who had reasonable grounds to suspect that a resident was abused by a PSW, immediately reported the suspicion and the information upon which it was based to the Director.

Sources: Critical incident system report, and an interview with an ADOC.

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)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the home's falls prevention and management program which provided for strategies to reduce or mitigate falls, including the application of a device was followed for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidents of falls and the risk of injury and ensure that it was complied with.

Specifically, the home failed to comply with their fall prevention and management policy when a device was not applied as indicated in a resident's care plan.

Sources: Interview with a PSW and an ADOC; review of a resident's care plan and home's policy titled, "LTC Falls Prevention and Management- Program", and home's investigation interview notes between a PSW and ADOC.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 1.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
1. Treatments and interventions to promote continence.

The licensee has failed to ensure that the home's continence care and bowel management program which provided interventions to promote continence, for a resident, was complied with.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a continence care and bowel management program which

provided treatments and interventions to promote continence and ensure that it was complied with.

Specifically, a PSW did not provide continence care assistance to a resident as indicated in their care plan.

Sources: Interview with a PSW and an ADOC ; record review of Critical Incident System, a resident's care plan, home's policy titled, "LTC Continence Care and Bowel Management- Program", and interview notes.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (d)
Infection prevention and control program
s. 102 (4) The licensee shall ensure,
(d) that the local medical officer of health appointed under the Health Protection and Promotion Act or their designate is invited to the meetings;

The licensee has failed to ensure that the local medical officer of health appointed under the Health Protection and Promotion Act or their designate was invited to the quarterly infection and prevention meetings.

Sources: Interview with the Administrator, record review of IPAC quarterly meeting minutes.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act when a Covid 19 outbreak was reported the following day after the outbreak as declared.

Sources: interview with Director of Care, a Critical incident system report.