Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 29, 30, 31, Jun 1, 26, 27, 2012	2012_099188_0018	Complaint

Licensee/Titulaire de permis

VALLEY EAST LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

Long-Term Care Home/Foyer de soins de longue durée

ELIZABETH CENTRE
2100 Main Street, Val Caron, ON, P3N-1S7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nursing staff (RN/RPN), Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) observed staff interactions with residents, reviewed various policies and procedures, reviewed health care records and reviewed the home's investigation related to abuse allegations.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's written policy to promote zero tolerance of abuse and neglect of residents. Inspector noted the policy was dated April 2002 and revised May 2007 and July 2008. Inspector noted the policy does not include any direction related to Mandatory Reporting under s.24 of the Act. Inspector noted the policy has not been updated to include requirements as identified in the regulations. The licensee failed to ensure that there is in place a written policy for promoting zero tolerance of abuse and neglect of residents which meets the requirements of the LTCHA s. 20(2). [LTCHA 2007, S.O. 2007, c.8, s.20(2)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. Inspector noted it identifies the home will continue to investigate the allegations of abuse. Inspector noted the critical incident report was never amended and the results of the investigation were not reported to the Director. The inspector spoke with the Director of Care who confirmed the investigation had completed and the results had not been reported to the Director. The licensee failed to ensure that the results of the abuse or neglect investigation are reported to the Director. [LTCHA 2007, S.O. 2007, c.8, s.23(2)]
2. Inspector reviewed a critical incident report. Inspector noted it identifies the home will continue to investigate the allegations of abuse. Inspector noted the critical incident report was never amended and the results of the investigation were not reported to the Director. The inspector spoke with the Director of Care who confirmed the investigation had completed and the results had not been reported to the Director. The licensee failed to ensure that the results of the abuse or neglect investigation are reported to the Director. [LTCHA 2007, S.O. 2007, c.8, s.23(2)]
3. Inspector reviewed a critical incident report. Inspector noted it identifies the home will continue to investigate the allegations of abuse. Inspector noted the critical incident report was never amended and the results of the investigation were not reported to the Director. The inspector spoke with the Director of Care who confirmed the investigation was completed and the results had not been reported to the Director. The licensee failed to ensure that the results of the abuse or neglect investigation are reported to the Director. [LTCHA 2007, S.O. 2007, c.8, s.23(2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. Inspector noted the allegations of abuse were reported to the Director outside the immediate reporting time frame. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]
2. Inspector reviewed a critical incident report. Inspector noted the resident to resident physical abuse resulting in injury was reported outside of the immediate reporting time frame. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]
3. Inspector reviewed a critical incident report. Inspector noted the allegations of verbal abuse were reported outside the immediate reporting time frame. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]
4. Inspector reviewed a critical incident report. Inspector noted the resident to resident physical abuse resulting in injury was reported outside of the immediate reporting time frame. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. Inspector reviewed the home's written policy on minimizing the restraining of residents. Inspector noted the policy was dated May 2007 and did not include any further revision dates. Inspector noted the policy has not been updated to ensure that any necessary restraining is done in accordance with the Act and regulations. The inspector also noted the policy directs staff to maintain paper documentation; however the home is now utilizing electronic records. The licensee failed to ensure their written policy for the minimizing of restraining of residents ensures that any restraining that is necessary is done in accordance with the Act and the regulations. [LTCHA 2007, S.O. 2007, c.8, s.29(1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Inspector reviewed a critical incident report. Inspector spoke with the Director of Care who identified that the investigation related to alleged verbal abuse and neglect had completed however the substitute decision-maker had not been notified of the results of the investigation. The licensee failed to ensure that the resident and the resident's substitute-decision maker are notified of the results of the investigation immediately upon the completion of the investigation. [O.Reg. 79/10, s.97(2)]
2. Inspector reviewed a critical incident report. Inspector spoke with the Director of Care who identified that the investigation related to alleged verbal abuse had completed however the substitute decision-maker had not been notified of the results of the investigation. The licensee failed to ensure that the resident and the resident's substitute-decision maker are notified of the results of the investigation immediately upon the completion of the investigation. [O.Reg. 79/10, s.97(2)]
3. Inspector reviewed a critical incident report. Inspector noted it identified an incident of neglect and verbal abuse. Inspector spoke with the Director of Care who identified when first made aware of the allegations the investigation began immediately. It was identified that the substitute decision-maker was not notified of the allegations until the following day. This is outside the 12 hour time frame. The licensee failed to ensure that the resident's substitute decision-maker is notified within 12 hours of the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [O.Reg. 79/10, s.97(1)(b)]
4. Inspector reviewed a critical incident report. Inspector noted that the report identifies an incident of alleged staff to resident abuse. It was reported to the inspector, by the Director of Care, that substitute decision-maker for the alleged victim was not notified of the allegations until two days following the incident. This is outside of the 12 hour time frame. The licensee failed to ensure that the resident's substitute decision-maker is notified within 12 hours of the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [O.Reg. 79/10, s.97(1)(b)]
5. Inspector reviewed a critical incident report. Inspector noted that the report identifies an incident of resident to resident physical abuse resulting in injury. Inspector noted that the substitute decision-maker was not notified until four days after the incident. This is outside of the immediate notification period. The licensee failed to ensure that a resident's substitute decision-maker is immediately notified of the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. [O.Reg. 79/10, s.97(1)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring substitute decision-makers are notified as follows; (a)immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and(b) within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident and immediately upon the completion of the investigation, to be implemented voluntarily.

Issued on this 27th day of June, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs