Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 12, 2013	2012_099188_0044	S-000980-12	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

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

This inspection was conducted on the following date(s): October 25-26, 2012

The following logs were reviewed as part of this inspection: S-000665-12, S-000792-12, S-000793-12, S-000852-12, S-000853-12, S-000984-12, S-000980-12, S-001213-12.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Co-Directors of Care, Registered Nursing Staff, Personal Support Workers, Families and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records, reviewed medication incident reports and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Critical Incident Response

Falls Prevention

Medication

Pain

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. Inspector reviewed a complaint letter identifying missing pain patches from which had been applied to the resident. Inspector noted the letter identifies three incidents that the resident's pain patches were unaccounted for. Inspector reviewed the health care record including progress notes and the medication administration record that confirmed the three incidents of missing pain patches. Inspector asked to review the home's medication incident documentation. Only one of the three incidents was documented. It was reported to the inspector that there was no medication incident documentation for the other two incidents. The licensee failed to ensure that every medication incident involving a resident is documented. [s. 135. (1)]

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 to ensure every medication incident involving a resident is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

s. 6. (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care. 2007, c. 8, s. 6 (12).

Findings/Faits saillants :

1. Inspector reviewed the plan of care for resident #980. Inspector noted the resident's advance directives were signed directing staff to initiate CPR and transfer to acute care in the event of a change in the resident's medical condition, a life threatening condition or a witnessed cardiac arrest. Inspector noted this document was signed by the resident's substitute decision-maker, a witness and the resident's primary physician. The resident was found to be unresponsive by staff. Inspector reviewed documentation and interviewed staff and the resident's family, all of whom confirmed CPR was not initiated and the resident was not transferred to acute care, despite the change in the resident's medical condition. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. Inspector interviewed resident #980's substitute decision maker (SDM). It was identified to the inspector that upon the resident's admission to the home the SDM was presented with a form to sign to indicate the resident's advance directives. The SDM identified this form was signed identifying the resident should receive CPR and be transferred to acute care in the event of a change in the resident's medical condition, a life threatening condition or a witnessed cardiac arrest. The resident was found unresponsive and CPR was not initiated and the resident was not transferred to acute care. The resident's SDM identified to the inspector that the home claims that due to a statement within the form that states "witnessed cardiac arrest" that the resident was not transferred to acute care as the change in condition was not witnessed. The SDM identified that this was not explained when the form was signed and the expectation had been the resident would receive CPR and be transferred to acute care when found unresponsive. The licensee failed to ensure that the resident's substitute decision-maker is given an explanation of the plan of care. [s. 6. (12)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

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Specifically failed to comply with the following:

s. 107. (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 (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Inspector was made aware of an unexpected death of a resident at the home that occurred. Inspector reviewed the health care record and confirmed that the death was unexpected. This unexpected death was never reported to the Director by the licensee. The licensee failed to ensure that the Director informed immediately, in as much details as possible, of an unexpected or sudden death, including death resulting from accident or suicide. [s. 107. (1)]

2. Inspector reviewed a complaint letter identifying missing pain patches from which had been applied to the resident. Inspector noted the letter identifies three incidents that the resident's pain patches were unaccounted for. Inspector reviewed the health care record including progress notes and the medication administration record that confirmed the three incidents of missing pain patches. Inspector noted these three incidents of missing or unaccounted controlled substance were never reported to the Director by the licensee. The licensee failed to ensure the Director is informed no later than one business day after a missing or unaccounted for controlled substance. [s. 107. (3)]

Issued on this 12th day of April, 2013

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