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 24, 2013	2013_138151_0012	S-000050-13,1384-13,1097-12	Critical Incident System

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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 4,5,8, 2013

This inspection relates to the following:
- S-001097-13 and related CI:2868-000027-12
- S-001344-12 and related CI:2868-000035-12
- S-000050-13 and related CI:2868-000012-13

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care, Staff Educator, Registered Staff, Personal Support Workers, Residents and Families

During the course of the inspection, the inspector(s)
- directly observed the care and service delivery to residents,
- toured the home several times per day
- reviewed the home's policies, procedures and programs in regards to prevention of falls,
- reviewed the home's policies, procedures and programs in regards to the management of responsive behaviours
- reviewed residents' health care records

The following Inspection Protocols were used during this inspection:
Falls Prevention

Personal Support Services

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Inspector reviewed resident #001's health care records and noted that the resident had repeated falls. Post fall assessment identified the following contributing factors: tripping over feet, tripping over foot rest, trying to go to the bathroom. In addition, progress notes identified a resident behaviour as a further contributing factor. Inspector reviewed the resident's plan of care and noted that there was no reference to resident behaviours and identified contributing factors and that there were no strategies that addressed these factors and behaviours. The resident's plan of care is incomplete and as such does not set out clear directions to staff and others who provide care to the resident. [s. 6. (1) (c)]

2. Resident #002 sustained an injury as the result of a fall. Inspector reviewed the resident's health care records and noted references identifying the resident-specific behaviours contributing to the risk of falls. In addition the Inspector observed the resident had transfer equipment installed in the room. Inspector reviewed the resident's fall management plan of care and noted that there was no reference to the use of the transfer equipment and the resident's behaviours. The resident's plan of care is incomplete and as such does not set out clear directions to staff and others who provide care to the resident. [s. 6. (1) (c)]

3. Inspector reviewed the health care records for resident #003 and interviewed direct care staff. Both of these indicated that the resident had resident-specific responsive behaviours. Inspector reviewed the resident's management of responsive behaviours plan of care and did not find any reference to the identified behaviours.
The resident's plan of care is incomplete and as such does not set out clear directions to staff and others who provide care to the resident. [s. 6. (1) (c)]

4. Inspector reviewed the health care records for resident #004 and noted that the resident exhibited resident specific responsive behaviours. Most significant was the behaviour of aggression towards others. Staff interviews confirm that the resident exhibited these behaviours. Inspector reviewed the resident's care plan and noted no reference to the identified responsive behaviours. The plan of care is incomplete and as such does not set out clear directions to staff and others who provide direct care to the resident [s. 6. (1) (c)]

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 that the residents' plans of care for resident's #001,002,003 and 004 provide clear directions to staff who provide care to the residents, to be implemented voluntarily.

Issued on this 25th day of April, 2013

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

Monique G. Berger (151)