



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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
Direction de l'amélioration de la
performance et de la conformité**

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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 25, 2013	2013_138151_0011	S-001350-12	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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection



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

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

Inspection is related to:

S-001350-12 and related IL-25741-SU

S-001351-12 and related CI:2868-000037-12

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care, Registered Staff, Personal Support Workers, Staff Education Co-ordinator, and residents.

During the course of the inspection, the inspector(s)

- made direct observations of the delivery of care and services to residents.
- did daily walk-through of the home
- reviewed resident health care records
- reviewed policies and procedures related to the prevention of resident abuse,
- reviewed the home's programs in regards to the management of responsive behaviours

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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 LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. Inspector toured the home and could not locate the following postings: policy on zero tolerance of abuse, home's procedure for initiating complaints, copy of restraint policy, policy on whistle blowing protection. Inspector requested the aid of the Staff Education RN to assist in locating the postings. Staff Educator confirmed that these policies were not posted. The home did not ensure that required information was posted in a conspicuous and easily accessible location. [s. 79. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. Inspector toured the home and noted that the morning medication passes were in progress on all four units. On one home area, Inspector noted that staff and student nurse had pre-poured 12 medication cups of liquid medications. Inspector confirmed that these cups of different medications were for different residents. In discussion with the Inspector, staff confirmed the pre-pouring of medication was not in accordance with the home's policy and that it did not meet College of Nurses Standard. Staff stated that it was a means to be more efficient and that, to date, the staff member had not been corrected by any supervisor to do otherwise.

On another home area, Inspector observed a medication cart in the hallway outside the dining room to be unlocked. No staff were near or within view of the cart. Inspector was able to open the drawers. Inspector waited by the cart for 1 minute 30 seconds before the RN student returned to the cart. Inspector located the student's home staff preceptor in the dining room and advised this person of the occurrence.

The home did not ensure that the medication management system provided for safe medication management that optimized effective drug therapy outcomes for residents. [s. 114. (1)]



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Issued on this 25th day of April, 2013

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

Monique S. Berger (151)