Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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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Inspection Report under the LTC Homes Act, 2007 X Public Copy Licensee Copy	**Rapport d'inspection prevue de le Loi de 2007 les foyers de soins de longue durée** Copie du Titulaire X Copie de la Publique	
Date(s) of inspection/Date de l'inspection July 5 – 8, 2010	**Inspection No/ d'inspection** 2010_106_2868_05Jul19 3007	**Type of Inspection/Genre d'insptection** Complaint
Licensee/Titulaire Valley East Long Term Care Centre Inc.		
Long-Term Care Home/Foyer de soins de longue durée Elizabeth Centre		
Name of Inspector(s)/Nom de l'inspecteur(s) Margot Burns-Prouty (ID# 106), Monique Berger and Gail Peplinski		

Inspection Summary/Sommaire d'inspection

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

The purpose of this inspection was to conduct a/an complaint inspection

The inspection was conducted by Margot Burns-Prouty, Monique Berger and Gail Peplinski.

The inspection occurred on July 5 – 8, 2010.

During the course of the inspection, the inspector(s) spoke with:
MEMBERS OF THE MANAGEMENT TEAM, INCLUDING THE ADMINISTRATOR AND DIRECTOR OF NURSING AND PERSONAL CARE; RESIDENTS WHO RESIDE ON HOME AREA TWO; STAFF ON THIS RESIDENT HOME AREA. A REVIEW OF THE RESIDENT'S RECORD WHO WAS NAMED IN THE COMPLAINT WAS COMPLETED.

The following Inspection Protocols were used in part or in whole during this inspection:

- **PERSONAL SUPPORT SERVICES**
- **SAFE AND SECURE**
- **DIGNITY**
- **SNACK OBSERVATION**
- **FALLS**

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

9 Findings of Non-Compliance were found during this inspection. The following action was taken:
9 WN
3 VPC
0 Co: CO#

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Plan of correction/Plan de redressement
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Acitvity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN#1: The Licensee has failed to comply with the Long-Term Care Homes Program Manual Standards and Criteria.

Criterion A1.11 (1): Every resident has the right to be treated with courtesy and respect and in a way that fully recognized the resident's dignity and individuality and to be free from mental and physical abuse.

Findings:
There is photographic evidence of one incident related to compromised respect and dignity. A photograph was taken of a resident lying in bed with a body part fully exposed and visible from the doorway.

Inspector ID#: 106

WN#2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 6(1)(c):
EVERY LICENSEE OF A LONG-TERM CARE HOME SHALL ENSURE THAT THERE IS A WRITTEN PLAN OF CARE FOR EACH RESIDENT THAT SETS OUT, CLEAR DIRECTIONS TO STAFF AND OTHERS WHO PROVIDE DIRECT CARE TO THE RESIDENT. 2007, C. 8, S. 6 (1).

Findings:
Review of a resident's written plan of care during July 5-8, 2010 inspection shows that it does not set out clear directions to staff and others who provide direct care to the resident on how the resident is to be repositioned in relation to recent change in resident's health status.

Inspector ID#: 106

WN#3: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c. 8, s. 6(9)2:
THE LICENSEE SHALL ENSURE THAT THE FOLLOWING ARE DOCUMENTED: THE OUTCOMES OF THE CARE SET OUT IN THE PLAN OF CARE.

Findings:
This requirement is not met as found by direct observations made on July7, 2010 of the afternoon fluid and nutritional pass,
1. Two residents, in home area 2 were observed to not receive a food snack however documentation on these same residents showed that they had consumed 100% of the snack.
2. Generally staff documented on residents that they had taken 100% of fluids before items were actually consumed. No staff was noted to return and verify actual intake.

VPC- Pursuant to LTCHA, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 6(9)2 in respect of written notification 3. This is to be implemented voluntarily.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

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Required Compliance Date for VPC: Immediate

WN#4: The Licensee has failed to comply with The Long-Term Care Homes Program Manual Standards and Criteria.

Criterion B2.61: When transferring or positioning a resident, staff shall use safe transferring and positioning techniques and equipment.

Findings:
A staff member used *unsafe transferring techniques and equipment when transferring a resident* to the dining room in a wheel chair. The staff member chose to use the wheel chair without the required foot rests and the resident fell forward out of the wheel chair. This is verified by the accounts of the critical incident report, falls incident report, and family written account that the resident fell as the direct result of staff failing to apply the required foot rests to resident's wheel chair.

VPC- Pursuant to LTCHA, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with CRITERION B 2.61 in respect of written notification 4. This is to be implemented voluntarily.

Inspector ID#: 106

Required Compliance Date for VPC: Immediate

WN#5: The Licensee has failed to comply with The Long-Term Care Homes Program Manual Standards and Criteria.

Criterion B4.1: Changes in each resident's condition, as well as any other significant information, shall be promptly reported to the staff member in charge of the resident's care.

Findings:
THIS REQUIREMENT WAS NOT MET IN THIS INSTANCE. A PSW OPTED TO REMOVE FOOT RESTS AND USE THE WHEEL CHAIR WITH OUT THEM INSTEAD OF SEEKING REPAIR AND DID NOT REPORT THE CONDITION OF THE CHAIR TO THE STAFF MEMBER IN CHARGE OF THE RESIDENT'S CARE. THE SPECIFIED DECISION MAKER WAS NOT NOTIFIED BEFORE STAFF MEMBER OPTED TO USE WHEEL CHAIR WITHOUT FOOT RESTS. THIS IS VERIFIED BY THE ACCOUNTS OF THE CRITICAL INCIDENT REPORT, FALLS INCIDENT REPORT AND FAMILY WRITTEN ACCOUNT.

Inspector ID#: 106
Required Compliance Date: Immediate

WN#6: The Licensee has failed to comply with The Long-Term Care Homes Program Manual Standards and Criteria.

Criterion **B5.2: The care and services provided to each resident shall be documented in the resident's**

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Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

record according to facility policies and procedures.

Findings:
In reference to the incident where a resident fell forward out of a wheel chair while being portered to the dining room, this requirement is not met. This is found by file review that shows the incident note stating that "no falls follow-up" was done. Further review of documented progress notes show no further formal falls follow-up notes were completed.

Staff interviewed state that the established protocol is to do the initial incident note then a follow-up falls report at the end of every shift for 72 hours. *There is no policy found to guide staff regarding this process*

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WN#7: The Licensee has failed to comply with: O. REG. 79/10, s. 50(2)(D):
Every licensee of a long-term care home shall ensure that, any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Findings:
This requirement was not met as found by direct observation of a resident. Ministry Inspectors observed the resident in her room 4 to 5 times per day on July 6 and 7, 2010. At no time was the resident found to be other than lying in the prone position.

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WN#8: The Licensee has failed to comply with: O. REG. 79/10, S. 72(3)(B):
The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, prevent adulteration, contamination and food borne illness.

Findings:

THIS REQUIREMENT IS NOT MET AS FOUND BY DIRECT OBSERVATIONS MADE. ON JULY 8, 2010 MINISTRY INSPECTOR OBSERVED PM NURISHMENT PASS. MINCED PUREED FRUIT CUP DATED AS PROCESSED JULY 4, 2010 WAS BEING OFFERED TO RESIDENTS. GUIDELINES USED BY THE HOME STATE FOOD PREPARED AND READY TO EAT SHOULD BE HELD FOR NO LONGER THAN 24 HOURS.

VPC- Pursuant to LTCHA, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 72(3)(B) in respect of finding 8. This is to be implemented voluntarily.

Inspector ID#: 106

Required Compliance Date for VPC: Immediate

WN#9: The Licensee has failed to comply with: O. REG. 79/10, S. 9.2:
Every licensee of a long-term care home shall ensure that the following rules are complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.

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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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

Findings:

THIS REQUIREMENT IS NOT MET AS FOUND BY DIRECT OBSERVATIONS MADE.
JULY 6, 2010 MINISTRY INSPECTOR OBSERVED ROOF EXIT #44 MECHANICAL ROOM DOOR TO BE UNLOCKED AND ACCESSIBLE TO RESIDENTS. THE ROOM WAS VERY WARM (GREATER THAN 30 DEGREES CELSIUS) AND THERE WAS EASY ACCESS TO ELECTRICAL PANELS AND EQUIPMENT LEVERS AND VALVES.

Inspector ID#: 106

Signature of Licensee of Designated Representative **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** Verbal report given to home July 9, 2010