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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 6, 2017	2017_570528_0007	028482-16, 001765-17	Complaint

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

VALLEY PARK LODGE
6400 VALLEY WAY NIAGARA FALLS ON L2E 7E3

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

CYNTHIA DITOMASSO (528)

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): February 15, 16, 17, 22, 24, 2017

This inspection was completed concurrently with Complaint Log #'s: 001579-17 related to outbreak policies and falls, 001785-17 related to staff to resident abuse, Critical Incident Inspection # 2017_570528_0008, and Follow Up Inspection # 2017_570528_0006.

During the course of the inspection, the inspector(s) spoke with the Administrators, Director of Care, Social Worker, Physician, Registered Dietitian (RD), Food Service Supervisor (FSS), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), office administration, residents and families.
During the course of the inspection, the inspector also observed the provision of care and services, reviewed documents including but not limited to: clinical health records, policies and procedures, complaints log, education records, plan of corrective action, and staffing schedules

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee shall ensure that the plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

During the course of the inspection, it was identified that the home's Falls Prevention and Management Program policies did not direct staff to use a post-fall assessment instrument that was specifically designed for falls.
i. Ontario Regulations 79/10 s. 49(2) required that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.
ii. Interview with the Administrator and DOC confirmed that home did not have a policy that directed staff what to do when a resident had fallen, including but not limited to, using a clinically appropriate post fall assessment tool. The Administrator identified that staff were able to use the Post Fall Assessment located under the assessments tab in Point Click Care, but was not specified in a policy. (528) [s. 8. (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 to ensure that the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A. The plan of care for resident #111 identified that the resident was high risk for falls.
i. On an identified day in December 2016, the resident reported they fell. Review of the plan of care did not include a post fall assessment using a clinically appropriate assessment tool designed for falls. Interview with RN #100 confirmed that a post fall assessment using a clinically appropriate assessment tool was not completed by registered staff when the resident reported they had fallen.
ii. On an identified day in January 2017, the resident reported that they had fallen. Review of the plan of care did not include a post falls assessment using a clinically appropriate assessment tool. Interview with RN #100 and the Administrator confirmed that a post fall assessment using a clinically appropriate assessment tool was not completed. (528)

B. The plan of care for resident #112 identified that the resident was at risk for falls. The resident was noted to have an fall on an identified date in December, 2016. Review of the plan of care did not include a post fall assessment using a clinically appropriate assessment tool. Interview with RN #100 and the Administrator confirmed that a post fall assessment was not completed using a clinically appropriate assessment tool specifically designed for falls. (528) [s. 49. (2)]

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 when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and

(f) any response made by the complainant

A. The home's policy Complaints Procedures CA-02-14-1 dated May 2010, confirmed that all complaints verbal and written were to be recorded on the home's complaints log summary sheet. If a more detailed report is necessary, it would be completed and attached to the complaints log, including all information listed in Ontario Regulation 79/10 s. 101(2).

B. In October 2016, resident #100 identified concerns to the home. Interview with RN #100, RPN #102, SW #104 and PSW #107 confirmed that the home was aware of the resident's concerns, and as a result, additional interventions had been put into place. Review of the homes Complaints and Concerns Log from 2016 to 2017, did not include the resident's concerns, the date the complaint was received, the homes action to resolve the complaint, dates responses were provided to the complainant, and complainant responses. Interview with the DOC and Administrator confirmed that the home's Complaint and Concern Log was not updated to include resident #100's concerns. (528)

C. In 2017, family of resident #111 raised concerns to nursing staff that the home did not notify the family member of a fall, where the resident sustained an injury. Review of the 2017 Complaints and Concern Log did not include the concerns. Interview with RN #100 and RPN #101 confirmed that the the home had completed an investigation into the concerns. Interview with the DOC and the Administrator confirmed that the home investigated the complainants concerns; however, was not included in the complaints log. (528)

D. Throughout the course of the inspection, resident #101 and family reported that the resident had misplaced personal items. The family reported that registered and Administrative staff were aware and looking for the items. Interview with RN #100 and DOC confirmed that the home was aware of the family's concerns that the resident had misplaced their items and were following missing items procedures. Review of the Missing Items Logs and the 2017 Complaints Log did not include any information regarding the concerns of resident #101's family related to missing items, as confirmed by the DOC. (528) [s. 101. (2)]

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 a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant, to be implemented voluntarily.

WN #4: 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. (5) 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 opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

The plan of care for resident #111 identified that they were able to make their own daily care decision. On admission, the resident's emergency contact was updated to include a family member. In January 2017, the resident reported to staff that they had fallen resulting in an injury. Progress notes indicated that the emergency contact for the resident was upset that they were not informed of the fall. The resident had a second fall and interview with RPN #102 and the Administrator confirmed that the family was not notified of the second fall either.

After the family contact expressed concern that they were not notified of the first fall, they were not notified of a second fall and therefore, not provided the opportunity to participate fully in the development and implementation of the plan of care. (528) [s. 6. (5)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

In December 2016, the home declared enteric outbreak with 47 confirmed cases. As a result of the outbreak, the home was providing bed baths to residents in their room. Review of the PSW Minimum Data Set (MDS) Flow Sheets for resident #111, identified that a minimum of two scheduled baths were not documented consistently in December 2016. Interview with RPN # 101, PSW #105 and PSW #106 confirmed that during the home's outbreak bed baths were given twice a week to all residents, but were not documented on the MDS Flow Sheet, as required. (528) [s. 30. (2)]

Issued on this 7th day of March, 2017

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

Original report signed by the inspector.