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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2017	2017_577611_0024	023930-17	Resident Quality Inspection

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

KELLY CHUCKRY (611), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 19, 20, 23, 24, and 25, 2017.

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care, reviewed applicable clinical health records, policies, procedures, practices, and observed medication administration practices in the home. One follow-up inspection, and two onsite inquiries were conducted concurrently with this Resident Quality Inspection. The follow-up inspection was Log #005331-17, pertaining to nutrition and hydration. The two onsite inquiries included Log #022224-17, and Log #023233-17, both pertaining to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the senior Administrator, the Administrator/Director of Care, MDS-RAI Coordinator, Food Service Manager, Registered Dietitian (RD), residents, family members, registered staff, Personal Support Workers (PSWs), and administrative staff.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 69.	CO #001	2017_570528_0006	632

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, that they were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. On an identified date, a wound assessment was conducted by registered staff in the home for resident #007. During this assessment, it was determined that this resident had areas of altered skin integrity.

For an identified three month period of time, the areas of altered skin integrity should have received weekly assessment a total of twelve (12) times. These weekly skin assessments were not consistently completed for resident #007.

An area of altered skin integrity was first identified in the clinical records on an identified date. During the identified period of time, a total of seven (7) weekly assessments should have been completed, and a review of the clinical records indicated that no assessments were completed during this time.

A review of the clinical health records was conducted with registered staff #103. It was acknowledged that weekly skin assessments were not consistently completed for resident #007 for their areas of altered skin integrity. A subsequent interview was conducted with registered staff #101 and #102 and it was also acknowledged that the weekly assessments were not completed.

In an interview conducted with the Senior Administrator, and the Administrator/Director of Resident Care, it was acknowledged that the home did not assess the areas of altered skin integrity for resident #007, at least weekly.

B. A weekly skin assessment was completed for resident #011 in October 2017. This assessment indicated that this resident had areas of altered skin integrity.

For an identified three month period of time, the areas of altered skin integrity should have received weekly assessments. These weekly skin assessments were not consistently completed for resident #011.

In an interview conducted with registered staff #101, it was acknowledged that the weekly assessments were not completed for resident #011's areas of altered skin integrity.

In an interview conducted with the Senior Administrator, and the Administrator/Director of Resident Care, it was acknowledged that the home did not assess the areas of altered skin integrity of resident #011, at least weekly. [s. 50. (2) (b) (iv)]

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 a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, they are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: 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).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was (b) reported to the resident, and the resident's substitute decision-maker, if any.

A review of the Medication Incident Reports provided for the period of January 13, 2017, to October 9, 2017 was conducted. A total of 38 incidences were documented during this time frame. The portion of this form that indicated the resident and the resident's substitute decision maker (SDM) being notified was not completed for sixteen (16) of these incident reports.

In an interview conducted with the Senior Administrator and the Administrator/Director of Care, it was acknowledged that the resident, and the resident's SDM were not notified of all medication incidences. [s. 135. (1)]

2. The licensee has failed to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

A review of the Medication Incident Reports provided for the period of January 13, 2017, to October 9, 2017 was conducted. A total of 38 incidences were documented during this time frame.

In an interview conducted with the Senior Administrator and the Administrator/Director of Care, it was acknowledged that the home did not complete a quarterly review of all medication incidences and adverse drug reactions that have occurred in the home. It was further confirmed that to date, a quarterly review had not been completed in 2017. [s. 135. (3)]

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 quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and every medication incident involving a resident and every adverse drug reaction is (b) reported to the resident, and the resident's substitute decision-maker, if any, to be implemented voluntarily.

WN #3: 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was complied with.

In accordance with r. 68. 2 (a), that required a long term care home to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents that included the development and implementation, in consultation with a RD who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

The home's "Weight – Monitoring of Resident Weights" policy (revised May, 2017) indicated that the Registered Nurse (RN), or Registered Practical Nurse (RPN) would complete a referral to the Registered Dietitian (RD) as their response to residents' weight variances, that were two kilograms (kg) difference in weight from the previous month, if the cause of significant weight change was unknown or required a change in food and fluid texture.

A review of resident #009's weight history contained information about a significant weight variation for an identified period of time, over one (1) month. On an identified date, staff #100 indicated that the RPN staff was to be directed to complete the referral to the RD from the RN, if resident' significant weight changes were related to a nutritional cause.

During this period of time, the registered staff did not complete a referral for the nutrition assessment for the RD. On October 23, 2017, the RD indicated that no referral for nutrition assessment was submitted about resident #009's significant weight changes, which was acknowledged by the home's Senior Administrator and the Administrator/Director of Care.

The home's staff did not comply with the home's "Weight – Monitoring of Resident Weights" policy. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Upon reviewing information related to the Medication Management System, it was acknowledged by the Administrator and DOC that the home does not conduct an annual evaluation of the effectiveness of the medication management system. [s. 116. (1)]

Issued on this 3rd day of November, 2017

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

Original report signed by the inspector.