Ontario

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 prévue 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2019	2019_569508_0021	002065-19	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

ROSEANNE WESTERN (508)

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): August 21, 22, 23, 2019.

A complaint submitted to the Director, log #002065-19, related to resident care concerns including skin and wound care, unsafe transferring and hospitalization and change in condition was inspected.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed resident clinical records, relevant policies and staff training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered staff, Personal Support Workers (PSWs), family and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	Légende 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).

s. 6. (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #001.

During this complaint inspection, the complainant indicated to this inspector that they had care concerns related to the care and assessment of resident #001 prior to the resident's hospital admission in 2019. They also indicated that they wanted to ensure that the resident was getting the care they required and that staff were following the resident's plan of care.

A review of the resident's clinical record identified that resident #001 had multiple comorbidites and had a history of an identified risk. During a review of the resident's clinical record it was identified that the resident had been hospitalized in 2019 with an identified diagnosis.

A review of the resident's current care plan indicated that the resident was at risk in an identified area based on their assessment. One section of the resident's care plan indicated that the resident was at high risk in this area. Further review of the same care plan identified that the resident was at low risk.

During review of the resident's care plan with registered staff #103, the staff confirmed that it was not clear on the plan whether or not the resident was at high or low risk for this identified concern.

It was confirmed during documentation review and during interview with registered staff #103 that the plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #001 covered all aspects of care, including medical, nursing, personal support, nutritional and dietary care.

During review of the resident's progress notes, it was identified that resident #001 had started to complain about new pain on an identified date. The progress notes indicated that the resident continued to report intermittent periods of this pain until the resident was transferred to hospital due to a change in their condition.

During this period, on two identified dates, progress notes indicated that family reported to staff that they had concerns about the resident's condition as the resident had a history of exhibiting this type of pain when this condition occurred.

Progress notes indicated that on an identified date in 2019, the resident was transferred to hospital due to a change in their condition.

During review of the resident's current clinical record during this inspection, it was identified that the resident's risk and history of this diagnosis had not been included in the resident's clinical record.

Review of the resident's clinical records and interview with registered staff #103 confirmed that the resident's plan of care did not include the resident's risk or history of this diagnosis. [s. 6. (3)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During this complaint inspection, the complainant indicated to this inspector that they had care concerns related to the care and assessment of resident #001 prior to the resident's hospital admission on an identified date in 2019.

During review of the resident's progress notes and pain assessment, it was identified that on an identified date in 2019, resident #001 reported that they had a specific type of pain which they rated as a 10/10 for the current level of pain. Resident #001 had a history of chronic pain and was administered routine analgesics; however, the resident did not complain of this specific pain regularly.

A pain assessment using a clinically appropriate assessment instrument was completed by registered staff upon the onset of this pain and the resident was administered their routine analgesic and a PRN (when necessary) analgesic for their pain.

Progress notes indicated that the analgesics were ineffective. Several hours later, a pain re-assessment indicated that the resident's pain level remained at a 10/10. PRN (when necessary) analgesics were administered again; however, were still ineffective. Documentation reviewed in the progress notes indicated that the resident still had no improvement with their pain which still remained a 10/10.

Review of the clinical records indicated that the resident's pain was being monitored and analgesics were being administered; however, a pain assessment using a clinically appropriate assessment instrument had not been conducted when their pain had not been relieved by initial interventions.

Review of the resident's clinical records and interview with DOC #101 confirmed that the resident's pain had not been relieved by initial interventions and a pain assessment using a clinically appropriate assessment instrument specifically designed for this purpose had not been conducted again until nine days later. [s. 52. (2)]

Issued on this 16th day of September, 2019

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

Original report signed by the inspector.