Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Nov 30, 2021	2021_704682_0020	009600-21	Critical Incident System

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

AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 22, 23, 24, 2021.

The following Critical Incident System inspection was completed:
009600-21 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping, and residents.

During this inspection, the inspector toured the home and observed Infection Prevention and Control (IPAC) practices, residents and the provision of care, general maintenance, cleanliness and condition of the home and reviewed relevant clinical records, investigation notes, staffing schedules and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 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 has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied.

In accordance with Ontario Regulation 79/10 s. 48 (1) 1 and in reference to O. Reg s.30 (1) 1, which states that in respect of the organized falls prevention and management program there must be a written description of the program that includes relevant policies to reduce risk and monitor outcomes.

Specifically, staff did not comply with the licensee's policy for Falls Prevention and Management and Neurological Signs/Head Injury Routine. The licensee's policy stated that all residents suspected to have sustained an injury to the head were monitored closely for a period of 48 hours. Head injury routine (HIR) included vital signs, level of consciousness, pupils and hand-grips every 15 minutes for one hour, every hour for the next three hours, and every four hours until a 48 hour period from time of injury elapsed.

A) A resident had an unwitnessed fall. Staff found the resident and Head Injury Routine (HIR) was initiated. On a subsequent date, the resident had another fall and transferred to hospital for further medical intervention. A review of the resident's neurological assessment form, indicated that staff had not assessed and completed HIR at the required frequency post fall. The Registered Practical Nurse (RPN) and the Administrator confirmed that neurological vital signs/ Head Injury Routine was documented in paper format using the neurological assessment form. The Administrator acknowledged that HIR was not completed for the resident as required after the initial fall. By staff not completing neurological signs/head injury routine as required, the resident was at risk for staff missing cognitive and behavioural deficits and changes in condition related to their

fall.

Sources: Critical Incident Submission (CIS), Head Injury Routine Policy, Falls Prevention Policy, resident electronic medical record (EMR), Interviews with the Administrator and other staff.

B) A resident had a fall to the floor. HIR was documented as initiated. The following day, further documentation in the resident's progress notes identified that HIR continued. A review of the resident's neurological assessment form indicated that staff had not assessed and completed HIR at the required frequency post fall. The RPN confirmed that the resident had refused the neurological assessment but could not identify at which time/interval as that detail was not indicated on the form. The RPN and Administrator acknowledged that HIR was not completed for the resident as required. By staff not completing neurological signs/head injury routine as required, the resident was at risk for staff missing cognitive and behavioural deficits and changes in condition related to their fall.

Sources: The licensee's policies; Head Injury Routine, Falls Prevention, resident electronic medical record (EMR), Interviews with the RPN and the Administrator and other staff. [s. 8. (1)]

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 complied with, 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 a resident had fallen, they had a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A resident had an unwitnessed fall and staff found the resident on the floor.

The licensee's Fall Prevention policy stated that a "Post Fall Assessment" was completed in point click care (PCC) following all falls. Interventions in place are reviewed and any new interventions considered.

The resident's clinical record only included a nursing progress note of the incident. The nursing note did not identify a review or consideration of new interventions to prevent further falls. The Administrator confirmed that the post-fall assessment tool was not completed.

Sources: CIS, Falls Prevention Policy, resident electronic medical record (EMR), Interviews with the Administrator and other staff. [s. 49. (2)]

Issued on this 6th day of December, 2021

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

Original report signed by the inspector.