Hamilton Service Area Office
119 King Street West, 11th Floor
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Original Public Report

Report Issue Date September 19, 2022
Inspection Number 2022-1232-0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ______________________

Licensee
955464 Ontario Limited

Long-Term Care Home and City
Valley Park Lodge, Niagara Falls

Lead Inspector
Aileen Graba (682)

Inspector Digital Signature

Additional Inspector(s)
Karlee Zwierschke (740732)

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 9, 12, 13, 14, 2022

The following intake(s) were inspected:

- Log #006554-22 related to falls prevention and management.
- Log #004689-22 related to improper care/neglect.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s. 6 (7)*

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

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On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA.

As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (7) of the LTCHA.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Rationale and Summary

A resident fell and sustained an injury. As per the resident's care plan, the resident had a fall prevention intervention. Clinical records and a registered nurse (RN) confirmed that the fall prevention intervention was not in place at the time of the fall. By not having the appropriate falls interventions in place the resident was placed at risk of injury.

Sources: Resident progress notes and care plan, Interview with RN. [740732]

WRITTEN NOTIFICATION [NURSING AND PERSONAL SUPPORT SERVICES]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 36.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 36 of O. Reg. 79/10.

The licensee failed to ensure that staff used safe positioning techniques when assisting a resident.

Rationale and Summary

A resident was provided assistance by a personal support worker (PSW). The PSW indicated that the resident fell while they were provided assistance. The PSW reported the incident and the RN documented that they assessed the resident. The resident's plan of care identified an intervention to be in place when staff were providing assistance.

A registered practical nurse (RPN) confirmed that the resident's plan of care identified an intervention and that the PSW did not include that intervention or use safe positioning when they provided assistance to the resident.

By staff not safely positioning the resident while providing assistance, the resident was at risk of injury.

Sources: Complaint; the home's Risk Management Form; resident electronic medical record (EMR), Interviews with RPN and other staff. [682]

WRITTEN NOTIFICATION [ATTENDING PHYSICIANS AND RNS (EC)]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 [s.82, (1) a].

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 82 of O. Reg. 79/10.

The licensee failed to ensure that a physician or registered nurse in the extended class conducted an annual physical examination for a resident and produced a written report of the findings of the examination.

Rationale and Summary

A resident's clinical record did not include a written report of an annual physical examination for an identified time. The home's attending physician agreement directed the attending physician to complete and document an annual examination for each resident under their care. A Registered Nurse (RN) confirmed that the resident's annual physicals were not completed by the physician within the identified time.

The resident was at risk for unidentified and untreated medical issues when the required annual physical examinations were not completed and documented.

Sources: The home's attending physician agreement; resident electronic medical record including physical examination and medical assessments, Complaint, Interview with RN, and other staff. [682]

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WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL]

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s.102 (15) 1].

The licensee failed to ensure that the infection prevention and control lead designated worked regularly in that position on site at the home, with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

Rationale and Summary

The Director of Care (DOC) and Administrator both stated that the home did not have an Infection Prevention and Control (IPAC) lead, and that they both shared the role. The Infection Control Committee policy identified that the infection control coordinator (ICC) was the role of the Director of Care and/or Assistant Director of Care (ADOC).

The DOC confirmed there was not an ADOC at the home and acknowledged that IPAC was not their primary focus. They confirmed that their time spent on IPAC was less than 17.5 hours per week. The Administrator also acknowledged that IPAC was not their primary focus.

The residents were placed at risk for the transmission of infection when there was not staff designated as an IPAC lead, who performed that function in compliance with specific IPAC provisions within the Regulations.

Sources: Infection Control Committee policy, Interview with the DOC, Administrator and other staff. [682]

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.