Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: May 22, 2024	
Inspection Number: 2024-1232-0001	
Inspection Type: Complaint Critical Incident	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Valley Park Lodge, Niagara Falls	
Lead Inspector Tracey Delisle (741863)	**Inspector Digital Signature**
Additional Inspector(s) Meghan Redfearn (000765)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3 - 4, 9 - 12, 16 - 19, 2024
The inspection occurred offsite on the following date(s): April 5, 8, 22, 23, 2024

The following intake(s) were inspected:

- Intake: #00110288 - Abuse and Neglect Program.
- Intake: #00110846 - Falls Prevention and Management Program

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

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,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to provide a written plan of care for the use of a Personal Assistance Service Device (PASD) for a resident.

Rationale and Summary

A) During the inspection, it was observed that a Resident was using a PASD and the interventions to instruct the staff on how or when to use the PASD for the resident were not included in the clinical records and confirmed by staff multiple interventions were used.

Failure to provide a written plan of care for the use of a PASD, put the resident at increased risk for injury.

B) During the inspection, it was observed that a Resident's call bell was used in multiple ways. Interviews with staff and the clinical records reviewed, determined that there was no clear direction in the plan of care on when and how to use the call bell.

Failure to provide clear direction for the use of the call bell put resident at risk for injury.

Sources: Observation of resident, Internal Policy, interview with staff, Resident clinical records, [741863]

WRITTEN NOTIFICATION: PASDs that limit or inhibit movement

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (1)
PASDs that limit or inhibit movement
s. 36 (1) This section applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD.

The Licensee has failed to appropriately apply the use of a PASD for Resident where resident is not able to release themself physically or cognitively from the PASD.

Rationale and Summary
During the inspection, it was observed that a Resident was using a PASD and the interventions to instruct the staff on how or when to use the PASD for the resident were not included in the plan of care.

An interview with Staff confirmed that they used the PASD, and the Staff also confirmed the resident would not be able to release the PASD themselves physically of cognitively.

The Home's Internal Policy, states "if the physical device was not removed upon the completion of the activity of daily living, the device would automatically become a restraint if the resident was not able to release the physical device themselves".

The failure to appropriately apply a PASD where the resident was unable to cognitively and physically release themselves from the PASD put the resident at risk for injury.

Sources: : Observation of resident, Internal Policy, interview with staff, Resident clinical records, [741863]

WRITTEN NOTIFICATION: Inclusion in plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 1.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

The licensee failed to ensure that when the PASD was used for a resident that alternatives to the use of a PASD was considered to assist with the routine activity.

Rationale and Summary
During the inspection it was observed that a resident had a PASD. The clinical assessment upon admission was completed for the resident and the resident was assessed to be high risk for the use of the PASD.

A review of the assessments also confirmed the Staff did not complete the assessments as identified in the prevailing practice guidance documents.

There was no evidence to indicate that other alternatives had been trialed prior to implementing the PASD for the resident and the Staff confirmed no other assessments were completed.

Failure to trial alternatives in accordance with prevailing practices increased the risk that the resident could be harmed when the PASD was being used.

Sources: Resident's clinical records, Internal Home Policies, Memo from Ministry of Long Term Care, Guidance Documents, Interview with Staff, Observations of resident. [741863]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that the resident's plan of care was implemented when they had a fall.

Rationale and Summary

On a day in March, 2024, a resident had an unwitnessed fall. The resident was found lying on the ground in their room.

The assessment indicated personal care was required.

On a day in March 2024, a Staff documented the resident's personal care that was provided and the interviews with Staff stated the resident was not provided with personal care as required.

There was an increased safety risk when resident was not provided personal care as required in the care plan.

Sources: Resident's plan of care; Resident List; interviews staff. [000765]

COMPLIANCE ORDER CO #001 Bed Rails

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

Bed rails

s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Amend or revise the Home's Internal Policy using evidence-based practice, if there are none, then prevailing practices to include:
   a) the requirement for an interdisciplinary team to be involved in a resident's bed rail use assessment.
   b) the requirement for each resident that uses one or more bed rails to be assessed over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails.
2. Re-assess the resident, using the amended policy before applying one or more bed rails for their use as described in the evidence-based practices, if there are none, prevailing practices.

3. Managers to review the revised policy and re-educate all registered staff and any other staff involved in bed rails management.

4. Document the education provided, including the names of the staff in attendance, date, and duration of the training, and who provided the education.

5. Keep a record of the training materials used and the date all education was completed for inspector review.

Grounds
The licensee failed to ensure when the bed rail was used for a resident, they were assessed, and evaluated in accordance with evidence-based practice, if there are none, then prevailing practices.

Rationale and Summary
During the inspection it was observed that a resident had a bed rail that was applied.

Interviews with Staff confirmed the bed rail was applied to assist the resident as a PASD. The clinical records did not include what bed rail alternatives were trialed prior to applying the bed rail, in accordance with evidence-based practice, if there are none, then prevailing practice documents.

There was no evidence to indicate that the resident had been reassessed or their bed system evaluated prior to the use of bed rails.

The failure to complete a bed rail safety assessment and a bed system evaluation in accordance with prevailing practices increase the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: Resident clinical records; Home's Internal Policies, Memo from Ministry of Long-Term Care, Guidance Documents, Interview with Staff, observations of resident. [741863]

This order must be complied with by: July 10, 2024

COMPLIANCE ORDER CO #002 Bed Rails

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 18 (1) (b)

Bed rails

s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Assess the Resident bed system for potential zones of entrapment if the resident will continue to use one or more bed rails in accordance with the evidence-based practice, if there are none, then prevailing practices.
2. Audit for 3 months the evaluation of each bed within the home that is occupied by a resident who uses one or more bed rails to ensure that each bed that has a bed rail attached and is in use, shall be assessed, evaluated, and documented using the methods, directions and frequency described in the evidence-based practice, if there are none prevailing practices.
3. Obtain and/or develop an education and information package that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the Substitute Decision Maker and licensee with respect to resident assessments,

the licensee's bed safety policies and procedures and any other relevant facts associated with bed systems and the use of bed rails.

Grounds

The licensee failed to ensure that when the bed rail was applied for a resident that their bed systems were evaluated for potential zones of entrapment.

Rationale and Summary

During the inspection it was observed that a resident had a bed rail.

There was no evidence in the clinical records or records provided by the home to confirm that the resident's bed was evaluated for entrapment after the bed rail was applied to the resident's bed. It was also confirmed, that the bed entrapments were not repeated when a bed rails were applied, or when the bed system was modified, therefore was not completed when Resident's bed rail was applied to the bed.

The failure to complete a bed system evaluation to assess all potential zones for entrapment when the bed rail was applied to the bed in accordance with prevailing practices increased the risk that resident could be harmed by becoming entrapped when bed rails were used.

Sources: Resident clinical records; Home's Internal Policies, Guidance Documents, Interview with Staff; Observations of resident. [741863]

This order must be complied with by: July 10, 2024

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;
(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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.