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

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Public Report

Report Issue Date: December 10, 2024
Inspection Number: 2024-1232-0004
Inspection Type: Critical Incident
Licensee: 955464 Ontario Limited
Long Term Care Home and City: Valley Park Lodge, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 2 - 5, 2024.

The following intake(s) were inspected:

- Intake: #00118010 -Critical Incident System (CIS) #2737-000004-24 - related to disease outbreak.
- Intake: #00126178 -CIS #2737-000006-24 - related to falls prevention and management.

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

Infection Prevention and Control
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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that admission assessments completed for a resident, were integrated, consistent and complimented each other.

Rationale and Summary
A resident was admitted with a known risk for falling. One admission assessment indicated they had difficulty following instructions and another admission assessment indicated they were able to follow instructions.

Interviews conducted confirmed the assessments had not been integrated, consistent and had not complemented each other.

When these assessments were not consistent, this had the potential to impact the goals and interventions of their fall plan of care, placing them at a higher risk of falling.

Sources: The resident's clinical assessment records, and interviews with the Administrator and Resident Assessment Instrument (RAI) Coordinator.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when they sustained falls with injury and their care needs changed.

Rationale and Summary

A resident's clinical records and a CIS indicated that within approximately two months since their admission, they sustained three falls, all with injury. The last fall required the home to submit a CIS.

A review of the resident's falls plan of care indicated the interventions had been implemented on their admission. No further revisions to their falls plan of care had been conducted following the two falls with injury preceding the submission of the CIS. Their falls plan of care had not included the review or implementation of restorative care approaches, referral to Physiotherapy, or the use of equipment, supplies, devices or assistive aids to assist in preventing further falls or minimizing injury.

Interviews with staff confirmed the resident's fall plan of care had not been revised when their care needs changed.

When the resident's care needs changed following two falls with injury and their falls plan of care had not been reviewed or revised, this had the potential to contribute to the third fall with injury.

Sources: Critical incident report, the resident's plan of care including their falls care plan, and interviews with the Administrator and RAI Coordinator.

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument.

Rationale and Summary
A resident's clinical records indicated they had fallen three times over a two-month period. Each fall resulted in injury.

A review of their clinical records, a CIS, and interviews conducted, indicated a post-fall assessment had not been conducted for any of these falls the resident sustained.

When a post-fall assessment using a clinically appropriate assessment instrument is not conducted following a residents fall, this has the potential to miss factors that may have contributed to the fall, and the plan of care not being revised to reflect interventions that may prevent future falls or minimize injury.

Sources: Critical incident report; the resident's clinical records including progress notes, assessments, and interviews with the Administrator and RAI Coordinator.