

## 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: October 18, 2024

Inspection Number: 2024-1232-0003

**Inspection Type:** 

Critical Incident

Follow up

IPAC

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): October 4, 7 - 11, 2024

The following intake(s) were inspected:

- Order Follow-up Bed rails
- Order Follow-up Bed rails
- Prevention of Abuse and Neglect
- Infection Prevention and Control

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control Prevention of Abuse and Neglect Restraints/Personal Assistance Services Devices (PASD) Management



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## **INSPECTION RESULTS**

## WRITTEN NOTIFICATION: Duty to Protect

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

#### Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from sexual abuse by a co-resident.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

#### **Rationale and Summary**

On a day in August 2024, it was documented in a resident's clinical records that a staff member witnessed resident to resident sexual abuse.

Clinical records and interviews with staff confirmed non-consensual sexual abuse of a resident towards a co-resident.

Failure to protect the resident, put the resident at risk for non-consensual sexual abuse.

**Sources:** Resident clinical records, Critical Incident, Interview with Staff. [741863]