

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

Public Report

Report Issue Date: November 17, 2025

Inspection Number: 2025-1232-0003

Inspection Type:

Complaint
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): November 5 to 7, 12 to 14, and 17, 2025.

The following intake(s) were completed in this Critical Incident (CI) inspection:
- Intake #00159598/CI#2737-000014-25 related to resident care and services

The following intake(s) were inspected in this complaint inspection:
- Intake #00159585 related to resident care and services.

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

Contenance Care
Resident Care and Support Services

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 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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On a specific date, a staff performed a procedure for a resident without following the required steps outlined in the plan of care.

Sources: Review of resident's clinical record, home's investigative notes; interviews with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

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

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

Continence care and bowel management

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

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

On a specific date, a resident did not receive assistance as outlined in their plan of care and was left in a continence product that was neither clean, dry, nor comfortable.

Sources: Review of resident's clinical record, home's investigative notes, review of CIS 2737-000014-25; interviews with staff.