



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection prévue
le Loi de 2007 les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119 rue King Ouest 11^{ième} étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Mar 17, 2017;	2017_570528_0006 (A1)	033986-16, 033991-16, 033992-16, 033993-16, 033994-16, 033995-16, 033996-16	Follow up

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

Long-Term Care Home/Foyer de soins de longue durée

VALLEY PARK LODGE
6400 VALLEY WAY NIAGARA FALLS ON L2E 7E3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CYNTHIA DITOMASSO (528) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié



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To Cindy Harbridge,

Further to our discussion on March 16, 2017, I have extended the compliance date for compliance order #001 related to inspection #2017_570528_0006 until May 26, 2017.

Attached is the amended Public Inspection Order Report for your records.

Sincerely,

Cynthia Di Tomasso

Issued on this 17 day of March 2017 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.



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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

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Amended Inspection Summary/Résumé de l'inspection modifié



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The purpose of this inspection was to conduct a Follow up inspection.

**This inspection was conducted on the following date(s): Feb 15, 16, 17, 22, 24,
2017**

**This inspection was completed concurrently with Follow Up Log #'s: 033986-16,
033991-16, 033992-16, 033993-16, 033994-16, 033995-16, 033996-16, Complaint
Inspection**

2017_570528_0007, and Critical Incident Inspection # 2017_570528_0007.

**During the course of the inspection, the inspector(s) spoke with the
Administrators, Director of Care, Social Worker, Physician, Registered Dietitian
(RD), Food Service Supervisor (FSS), registered nurses (RN), registered practical
nurses (RPN), personal support workers (PSW), office administration, residents
and families.**

**During the course of the inspection, the inspector also observed the provision of
care and services, reviewed documents including but not limited to: clinical
health records, policies and procedures, complaints log, education records, plan
of corrective action, and staffing schedules**

The following Inspection Protocols were used during this inspection:



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Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

2 WN(s)

1 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:



REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19.	CO #001	2016_205129_0005	528
LTCHA, 2007 s. 6. (1)	CO #003	2016_205129_0005	528
LTCHA, 2007 s. 6. (10)	CO #006	2016_205129_0005	528
LTCHA, 2007 s. 6. (2)	CO #004	2016_205129_0005	528
LTCHA, 2007 s. 6. (7)	CO #005	2016_205129_0005	528
O.Reg 79/10 s. 8. (1)	CO #008	2016_205129_0005	528



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

- 1. A change of 5 per cent of body weight, or more, over one month.**
- 2. A change of 7.5 per cent of body weight, or more, over three months.**
- 3. A change of 10 per cent of body weight, or more, over 6 months.**
- 4. Any other weight change that compromises the resident's health status. O.**

Reg. 79/10, s. 69.



Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status

A. The plan of care for resident #112 identified that the resident was at a nutritional risk. From November 2016 to December 2016, the resident's had a weight change. An assessment completed by the RD at the end of December 2016, documented that the resident had a change in status and if continued would require a nutritional intervention. In January and February 2017, the resident had further weight change and review of the plan of care did not include a nutritional intervention. Interview with the RD confirmed that the resident continued to have weight changes after December 2016, and a nutritional intervention was not implemented, as recommended. Therefore, action was not taken and outcomes were not evaluated after the resident had a significant weight change. (528)

B. The plan of care for resident #116 identified that the resident was a nutritional risk. From December 2016 to January 2017, the resident had a significant weight change and the resident was admitted to the hospital. In February 2017, the resident had additional an weight change. Review of the plan of care did not include an assessment by registered staff or the RD related to the weight change.

- i. The home's "Weighing Residents" policy, dated May 2016, directed registered staff to review monthly weights after the 10th of the month and any weight that was a significant change would be re-weighed. If the change in weight was confirmed then a referral to the RD was to be completed.
- ii. After the resident's significant weight change in January 2017, interview with RN #100 confirmed that the resident was not re-weighed and a referral was not sent to the RD. Furthermore, interview with the RD, RN #100, and the Administrator confirmed that the registered staff were not completing RD referrals related to significant weight changes. Instead, the RD reviewed the resident's weights independently and requested re-weighs if applicable. Also, RN #100 reported that if a large weight variance was noted a re-weigh would be requested, but registered staff did not review significant change weight loss and request re-weighs, as



required in the home's policy.

iii. Interview with the RD confirmed that the resident had ongoing weight changes ; however, a formal assessment of the significant weight change was not completed. (528) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :



1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. In 2016, resident #118 required a nutritional supplement three times a day with meals. Review of the resident's Nutritional Flow Chart from November 2016 and January 2017, identified that staff did not consistently document that the resident received the supplement. Interview with the FSS, PSW #110, RD, and the Administrator, confirmed that the Nutritional Flow Charts were reviewed monthly and PSW staff were not consistently documenting nutritional interventions, as required.

B. In 2016, resident #117 required a nutritional supplement twice a day. Review of the resident's Nutritional Flow Chart from November 2016 and February 2017, identified that staff did not consistently document that the resident received the supplement. Interview with the FSS, PSW #110, RD, and the Administrator, confirmed that the Nutritional Flow Charts were reviewed monthly and PSW staff were not consistently documenting nutritional interventions, as required. (528) [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.



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Issued on this 17 day of March 2017 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.



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Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the Long-Term
Care Homes Act, 2007, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la Loi de 2007 sur les
foyers de soins de longue durée, L.
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Name of Inspector (ID #) /

Nom de l'inspecteur (No) : CYNTHIA DITOMASSO (528) - (A1)

Inspection No. /

No de l'inspection : 2017_570528_0006 (A1)

Appeal/Dir# /

Appel/Dir#:

Log No. /

Registre no. : 033986-16, 033991-16, 033992-16, 033993-16,
033994-16, 033995-16, 033996-16 (A1)

Type of Inspection /

Genre d'inspection: Follow up

Report Date(s) /

Date(s) du Rapport : Mar 17, 2017;(A1)

Licensee /

Titulaire de permis : 955464 ONTARIO LIMITED
3700 BILLINGS COURT, BURLINGTON, ON,
L7N-3N6

LTC Home /

Foyer de SLD : VALLEY PARK LODGE
6400 VALLEY WAY, NIAGARA FALLS, ON,
L2E-7E3

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : JENNIFER ANDERSON



Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the Long-Term
Care Homes Act, 2007, S.O.
2007, c. 8

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foyers de soins de longue durée, L.
O. 2007, chap. 8

To 955464 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
Linked to Existing Order / Lien vers ordre existant:	2016_205129_0005, CO #007;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall ensure the following:

- a. that all resident's with a significant weight change, including but not limited to, resident #112 and resident #116, are assessed using an interdisciplinary approach and that actions taken and outcomes are evaluated.
- b. all nutritional care policies, procedures, and protocols in place in the Dietary and Nursing department manuals related to weight monitoring are reviewed and revised to reflect roles and responsibilities of each member of the interdisciplinary team
- c. the home's review of the nutritional care policies, including but not limited to, what changes are identified, is to be documented.
- d. all staff are educated on their roles and responsibilities related to the reviewed and revised nutritional care policies



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section 154 of the Long-Term
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l'article 154 de la Loi de 2007 sur les
foyers de soins de longue durée, L.
O. 2007, chap. 8

Grounds / Motifs :

1. A. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the noncompliance is pattern (2), with two out of three residents in the sample who were not assessed when there was significant weight changes, the severity of the non-compliance has a potential to harm residents (2) and the history of non-compliance under s. 69 of Ontario Regulation 79/10 is ongoing (4) with a CO issued in August 2016.

B. The plan of care for resident #112 identified that the resident was at a nutritional risk. From November 2016 to December 2016, the resident's had a weight change. An assessment completed by the RD at the end of December 2016, documented that the resident had a change in status and if continued would require a nutritional intervention. In January and February 2017, the resident had further weight change and review of the plan of care did not include a nutritional intervention. Interview with the RD confirmed that the resident continued to have weight changes after December 2016, and a nutritional intervention was not implemented, as recommended. Therefore, action was not taken and outcomes were not evaluated after the resident had a significant weight change. (528)

C. The plan of care for resident #116 identified that the resident was a nutritional risk. From December 2016 to January 2017, the resident had a significant weight change and the resident was admitted to the hospital. In February 2017, the resident had additional an weight change. Review of the plan of care did not include an assessment by registered staff or the RD related to the weight change.

i. The home's "Weighing Residents" policy, dated May 2016, directed registered staff to review monthly weights after the 10th of the month and any weight that was a significant change would be re-weighed. If the change in weight was confirmed then a referral to the RD was to be completed.

ii. After the resident's significant weight change in January 2017, interview with RN #100 confirmed that the resident was not re-weighed and a referral was not sent to the RD. Furthermore, interview with the RD, RN #100, and the Administrator confirmed that the registered staff were not completing RD referrals related to significant weight changes. Instead, the RD reviewed the resident's weights independently and requested re-weighs if applicable. Also, RN #100 reported that if a large weight variance was noted a re-weigh would be requested, but registered staff



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2007, c. 8

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l'article 154 de la Loi de 2007 sur les
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did not review significant change weight loss and request re-weighs, as required in the home's policy.

iii. Interview with the RD confirmed that the resident had ongoing weight changes ; however, a formal assessment of the significant weight change was not completed.
(528) (528)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

May 26, 2017(A1)



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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 to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director



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Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603



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foyers de soins de longue durée, L.
O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17 day of March 2017 (A1)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

CYNTHIA DITOMASSO

**Service Area Office /
Bureau régional de services :**

Hamilton