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
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Original Public Report

Report Issue Date: January 19, 2024	
Inspection Number: 2023-1232-0004	
Inspection Type: Critical Incident Follow up	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Valley Park Lodge, Niagara Falls	
Lead Inspector Erika Reaman (000764)	**Inspector Digital Signature**
Additional Inspector(s) Tracey Delisle (741863)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 19-21, 2023

The following intake(s) were inspected:

- Intake: #00084518/Critical Incident(CI): 2737-000003-23 - Fall of resident resulting in injury.
- Intake: #00095470/CI: 2737-000005-23 - COVID - Outbreak declared 24AUG23 - Finalized 11SEP23 - Second Home Area.
- Intake: #00100513/Follow-up- High Priority CO #001 / 2023_1232_0003, O. Reg. 246/22 s. 74 (2) (c) Nutritional care and hydration programs, CDD November 15, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order # from Inspection #2023-1232-0003 related to O. Reg. 246/22, s. 74 (2) (c) inspected by Tracey Delisle (741863)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A Critical Incident (CI) report was submitted, in relation to a respiratory outbreak. The administrator confirmed that it was declared by Public Health on a date in August. The Administrator and Infection Protection and Control Lead acknowledged that this was not immediately reported to the director.

When the director was not immediately informed there was a risk to residents that elements of the IPAC program were not being implemented properly.

Sources: Interview with Administrator; record review of CI 2737-000005-23 [000764]