



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 sous la Loi de 2007 sur les foyers de soins de longue durée

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Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2014	2014_248214_0004	H-000603- 13	Complaint

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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 22, 23, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, RAI (Resident Assessment Instrument) Coordinator, Registered Nurse(RN), Personal Support Workers(PSW), Recreation Therapist, family members and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed clinical records, relevant policies and procedures and staff training records.

The following Inspection Protocols were used during this inspection:



**Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours**

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

- s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
- 2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**



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Findings/Faits saillants :

1. The licensee did not ensure that every resident was protected from abuse.

According to the clinical record, resident #001 had known responsive behaviours, which included verbal abuse towards co-residents. On an identified date in 2013, staff observed resident #001, make "rude" remarks to resident #004 and on another identified date in 2013, overheard the resident use foul language toward the same resident. Resident #004 stated they had cried and felt "scared" as a result of these incidents. On an identified date in 2014, staff overheard the resident make "inappropriate" comments to resident #005. Resident #005 stated the remarks were degrading. The Administrator confirmed they were not made aware of any of these incidents and no investigation was conducted. [s. 3. (1) 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 every resident is protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :



1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

The home's policy Abuse-Prevention, Reporting And Elimination Of Abuse And Neglect (CA-05-37-1-13) indicated that any person who suspects that abuse or neglect had occurred must report it to the registered nursing staff who were required to immediately contact the Administrator or designate. Resident #001 was observed and documented by staff to have been involved in four incidents of verbal abuse toward co-residents on three identified dates in 2013 and one identified date in 2014. The Administrator was not made aware of these four incidents. It was noted that on all four occasions, staff took immediate actions and recorded the events in the clinical record. Registered staff did not report these incidents to the Administrator or designate, as required by the home's policy. This information was verified by the Administrator. [s. 20. (1)]

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 the written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :



1. The licensee did not ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's policy COMPLAINTS PROCEDURES (CA-02-14-1), indicated that 1) If a resident, family member or another complainant expresses a concern/complaint about the care of a resident or the operation of the home to any staff member, that staff member must report that concern/complaint to the Administrator or designate immediately and 5) All complaints, verbal and written must be recorded on the complaints log. If a more detailed report is necessary, it should be completed and attached to the complaints log.

a) A review of resident #002's clinical record, indicated that on an identified date in 2013, a family member of resident #002, placed a complaint to staff, regarding the care of resident #002. It was noted in the documentation that staff did notify the Director of Care, however a review of the home's complaint log, did not include this complaint and there was no documentation to indicate that the complaint had been investigated. This was verified by the Administrator.

b) A review of resident #002's clinical record, indicated that on an identified date in 2013, a family member of resident #002, placed a concern to staff regarding the care of resident #002. A review of the home's complaint log did not include this concern and there was no documentation to indicate that the concern had been investigated. This was verified by the Administrator. [s. 8. (1) (b)]



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Issued on this 18th day of February, 2014

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

A handwritten signature in cursive script, appearing to read "C. Fedras".