

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Toronto Service Area Office
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Toronto ON M4V 2Y7

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55, avenue St. Clair Ouest, 8^{ième} étage
Toronto, ON M4V 2Y7

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

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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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Date(s) of inspection/Date de l'inspection 16 September 2010	Inspection No/ d'inspection 2010_127_2737_15Sep161236	Type of Inspection/Genre d'inspection Complaint (H-00028)
Licensee/Titulaire 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		
Name of Inspector(s)/Nom de l'inspecteur(s) Richard Hayden - LTC Homes Inspector – Environmental Health #127		
Inspection Summary/Sommaire d'inspection		
The purpose of this inspection was to conduct a complaint inspection regarding privacy curtains and follow-up of items brought forth to residents' council. During the course of the inspection, the inspector spoke with the Director of Care, Maintenance person and Recreation Coordinator. During the course of the inspection, the inspector inspected several resident rooms to determine compliance based on the complaint information and reviewed minutes of residents' council meetings. The following Inspection Protocols were used during this inspection: - Residents' Council Interview - Safe and Secure Home ☒ Findings of Non-Compliance were found during this inspection. The following action was taken: 3 WN 1 CO: CO # 1		

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, .c.8. s. 57 (2). If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Findings:

16 September 2010

Review of Residents' Council minutes:

03 May 2010

"M-2 The screen in [a resident's room] is not fastened and there is a space, it was reported to the nurses but no one came to fix it. Leona offered to talk to Emmanuel about the screen."

10 June 2010

"OLD BUSINESS

Maintenance

[The] screen not fixed"

05 July 2010

"OLD BUSINESS

Maintenance

Screen was patched up in [a resident's room] resident is not happy with the job. Also would like to know where the new blinds promised for [the] room." Handwritten in the margin, "Note put in maintenance book"

No written response from the administrator within 21 days to the complaint of 03 May 2010.

No written response from the administrator within 21 days to the complaint of 10 June 2010.

No written response from the administrator within 10 days to the complaint and question of 05 July 2010.

Long-Term Care Facilities Program Standards & Criteria

A1.23 Suggestions and complaints from the residents' council shall be documented, investigated and responded to in writing by the administrator of the facility within 21 days.

Inspector ID #:

127

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Findings:

16 September 2010

Privacy curtains did not extend far enough to afford privacy to each bed simultaneously in Rooms 1, 4, 5, 6, 11 and 14.

Inspector ID #: 127

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 cm.

Findings:

16 September 2010

Slider windows in Rooms 6 and 18 were not restricted to 10 cm and could be fully opened.

Inspector ID #: 127

Additional Required Actions:

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

Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la
responsabilisation et de la performance du système de santé.

Title:

Date:

Date of Report: (if different from date(s) of inspection).

14 October 2010



Order(s) of the Inspector

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

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public
Name of Inspector:	Richard Hayden	Inspector ID # 127
Log #:	H-00028	
Inspection Report #:	2010_127_2737_15Sep161236	
Type of Inspection:	Complaint	
Date of Inspection:	16 September 2010	
Licensee:	955464 Ontario Limited	
LTC Home:	Valley Park Lodge	
Name of Administrator:	Jennifer Anderson	

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

Order #:	001	Order Type:	Compliance Order, Section 153 (1)(a)
Pursuant to: O. Reg. 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 cm.			
Order: The licensee, 955464 Ontario Limited, shall install and maintain window restrictors on all windows that open to the outdoors and are accessible to residents such that the windows cannot be opened more than 10 centimetres.			
Grounds: 16 September 2010 Slider windows in two residents' rooms were not restricted to 10 centimetres and could be fully opened.			
This order must be complied with by:		20 October 2010	



Ministry of Health and Long-Term Care
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Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

REVIEW/APEAL 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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

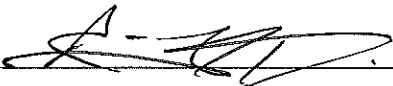
Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this <u>14</u> day of <u>October</u> , 2010.	
Signature of Inspector:	
Name of Inspector:	Richard Hayden
Service Area Office:	119 King St. West, 11th Floor, Hamilton, ON L8P 4Y7