Ontario

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

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

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

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 12, 2011	2011-120-2779-12May084140	H-00873-11 - Complaint

Licensee/Titulaire
Park Lane Terrace Ltd., 284 Central Avenue, London, ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée
Park Lane Terrace, 295 Grand River Street N, Paris, ON N3L 2N9

Name of Inspector(s)/Nom de l'inspecteur(s)
Bernadette Susnik, Environmental Health #120

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with the Administrator, a Registered Nurse and residents.

During the course of the inspection, the inspector reviewed the identified resident's records, policies and procedures on responding to internal complaints and documentation kept by the home following the receipt of a complaint.

The following Inspection Protocols were used during this inspection:

- *Accommodation Services - Laundry*
- *Reporting and Complaints*
- *Dignity, Choice and Privacy*

Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
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'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: ***The licensee has failed to comply with O. Reg. 79/10, s.101(1)3 & 101(2).*** Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. A response shall be made to the person who made the complaint, indicating,
   i. what the licensee has done to resolve the complaint, or
   ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

(2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;

(b) the date the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any;

(e) every date on which any response was provided to the complainant and a description of the response; and

(f) any response made in turn by the complainant.

Findings:

In 2011, an identified resident verbally complained to staff that money was missing from her purse. Less than one month later, she complained to staff that money was again missing from her purse. Both complaints were documented by staff in the resident's progress notes however no formal investigation ensued in either case. A response given by a home employee was to give her money to the office clerk. However, the resident does not have an account at the home.

In 2011, an identified resident verbally summarized all of their complaints to both the Director of Care and the Administrator. The resident had a meeting with both individuals at separate times. Notes made by both individuals were reviewed. Neither of the individuals followed the requirements set out in the Regulation as noted above with respect to the complaint process. The resident indicated that they received answers to some of their questions from nursing staff on days that they originally made the complaints , however the resident felt it was necessary to make a personal visit to the Administrator and Director of Care because they feel that the issues have not been truly resolved and that they continue.

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 in respect to ensuring that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as identified under section 101(1)3 and 101(2). The plan is to be implemented voluntarily.

WN #2: ***The license has failed to comply with the LTCHA 2007, S.O., 2007, c. 8, s. 84.*** Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

Findings:

The lost and found process in the home is not monitored, analyzed or evaluated to determine where improvements need to be made. Numerous unlabelled articles of clothing were noted in the laundry room, and the laundry staff did not know when the articles were acquired. No proactive programs are in place to manage the unlabelled articles in the laundry room. Family and residents are permitted to rummage through the articles when they believe something has gone missing. No proactive auditing is conducted to limit the number of unlabelled articles reaching the laundry room (closet checks, checking articles before sending to laundry etc.). Complaints from residents who claim that an article has been lost are not formally documented and the home does not keep track of how many complaints are lodged or resolved.

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 in respect to ensuring that the laundry service is part of the quality improvement and utilization review system that monitors, analyzes, evaluates and improves quality. The plan is to be implemented voluntarily.

WN #3 – The licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1. Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

In 2011, an identified resident, while lying in bed, had both of their legs physically grabbed by a personal care worker (PSW) who then swung them over to the side of the bed. The resident became very upset, and did not appreciate the roughness and suddenness of the action. They expressed their concerns to the PSW at the time and complained formally to the administrator of the home two days later.

WN #4 – ***The licensee has failed to comply with O. Reg. 79/10, s. 41.*** Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Findings:

An identified resident has not had their bedtime and rest routines supported to promote rest and sleep. An interview with the resident and a review of the notes made by staff in the resident's progress notes, confirm

that the resident has complained to staff about their room mate repeatedly, waking the resident in the middle of the night. The resident expressed their concerns to staff on 5 occasions. Based on the documented statements, it appears that the resident's stress level is escalating. The resident also made requests to the staff on two occasions, as to their preferred bed time and wake time, which is not being honored. The resident received responses such as the staff were too busy with other residents to honour the resident's preferences. Documentation with respect to these issues have been made in the progress notes, however no resolution is apparent.

Signature of Licensee of Designated Representative **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.** Tracey for Lisa Vinke **Report revised for the purpose of publication – October 27, 2011**
Title: **Date:**	**Date of Report :**(if different from date(s) of inspection).