Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur 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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 26, 2017	2017_574586_0007	006865-17	Complaint

Licensee/Titulaire de permis

PARK LANE TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

PARK LANE TERRACE
295 GRAND RIVER STREET NORTH PARIS ON N3L 2N9

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

JESSICA PALADINO (586)

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): April 6 and 7, 2017.

The inspection was completed for Complaint Inspection #006865-17 - Housekeeping, Residents' Rights, Dining and Snack Service, Food Production.

Critical Incident System (CIS) Intake 007489-17 was also inspected as an on-site inquiry as this arose during the Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager (FSM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary staff, residents and families.

During the course of the inspection, the inspector(s) toured the identified home area, observed resident care, observed meal service, reviewed resident health records, reviewed Family Council meeting minutes, reviewed cleaning schedules, and interviewed staff, families and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Food Quality
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were monitored during meals.

The home instituted a process in which family members who were coming in to assist their loved ones during meals would be required to do so in the activity room located beside the main dining room with a large lounge in between. There was no view of the activity room from the main dining room. Three family members voiced concern to the LTC Inspector about their family members not receiving proper monitoring during meals in the activity room while eating their meals.

During the inspection, meal service was observed. Residents #001 and #002 were in the activity room with their family members. Resident #002 was at a nutritional risk and required supervision to eat as per their plan of care. Resident #001 was at a nutritional risk due to a particular disease and required a texture-modified diet as per their plan of care. The residents were served their food at 1200 hours. No staff members came into the activity room or even came to look into the room to check up on the residents for the duration of the meal. This was confirmed by PSW #003. The residents were not monitored during their meal. [s. 73. (1) 4.]

2. The licensee has failed to ensure that meals were served course-by-course for each resident.

Three family members voiced concern to the LTC Inspector about having to assist their loved ones in the activity room rather than in the dining room, as directed by the home. The home instituted a process in which family members would request their meal choice to the staff who would bring it to the activity room on a tray. On two dates during the inspection, all three courses (soup, entrée, dessert) along with drinks were brought to the three residents in the activity room (resident #001, #002, #003) at the same time, whereas the residents in the main dining room received each one at a time, including coffee and tea toward the end of the meal. Resident #002's coffee was cold on their tray by the time they went to drink it after their meal. Residents eating in the activity room were not served course-by-course. [s. 73. (1) 8.]

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 all residents are monitored during meals, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A) A family member voiced concern to the Long-Term Care (LTC) Inspector of the state of the carpet in a particular home area. During the two-day observation on April 6 and 7, 2017, the carpets throughout the home area were observed to be heavily soiled with several large stains and discolouration. Housekeeping records and interview with the FSM, DOC and Administrator identified that the carpets were steam cleaned regularly; however, due to the type of stains, the cleaning does not remove the stains or improve the appearance of the carpet. This issue was identified during inspection in September 2016, and the home had initiated a plan to replace the carpets in the home; however, only one home area had been replaced, and the carpets in the identified home area have remained heavily soiled. The home did not ensure the carpets were kept clean.

B) A family member voiced concern to the LTC Inspector of dirty cutlery and dishware a certain home area. On an identified date during the inspection, just as residents were being brought into the dining room for a meal, several spoons set out on the tables were observed to be gritty, two having visible food stains. Four cups and three plates were noted to have food debris on them. Dietary staff #001 acknowledged that at times, they would notice cutlery that was not properly cleaned or inspected from the night before, likely due to the dishwasher not being drained properly by staff, or staff not checking prior to place setting. In an interview with the FSM they confirmed that after being washed, staff should be checking the cutlery and dishware to ensure there was no food debris or grittiness after it had been washed as well as prior to place setting. The home did not ensure the cutlery and dishware were kept clean and sanitary. [s. 15. (2) (a)]

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 home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 was protected from verbal abuse.

During meal service in a particular dining room during the inspection, resident #005 was observed leaving the dining room before the meal was served. Upon exiting the dining room, the LTC Inspector observed PSW #002 yell across the nursing station to the resident in an annoyed and frustrated tone. The LTC Inspector approached the PSW to ask them if what they said and how they spoke to the resident was appropriate, and it was acknowledged by the PSW. Interview with the FSM and DOC confirmed that the PSW's actions were inappropriate. Resident #005 was not protected from verbal abuse by PSW #005. [s. 19. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to prevent adulteration, contamination and food borne illness.

During the inspection, the LTC Inspector observed dietary staff #100 taking food temperatures prior to lunch service, including cottage cheese, roast beef, gravy, cauliflower, sausage, French toast, and pears, of varying textures. One resident in the dining room was a vegetarian. The staff member was not sanitizing the thermometer between testing each type of food, rather would just wipe it with a paper towel. They confirmed that this was how they always take temperatures. In an interview with the FSM, they indicated that the home's expectation was for staff to sanitize the thermometer when testing different foods to prevent contamination. The FSM acknowledged that there were plenty of sanitization wipes available in the servery for the staff, and acknowledged that the dietary staff was creating a risk for cross-contamination. [s. 72. (3) (b)]

Issued on this 30th day of May, 2017

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

Original report signed by the inspector.