Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 15, 2017	2017_556168_0026	015089-17	Critical Incident System

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 13, 2017.

This Critical Incident inspection was conducted related to certification of nurses.

This inspection was conducted concurrently with Follow Up inspection 012646-17, related to Inspection Report number 2016-556168-0029, for Compliance Order #001, related to Ontario Regulation 79/10 section 131(3) for administration of drugs. The area of non-compliance identified during the Follow Up inspection is included in this Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Director of Quality, Administrator, Director of Care (DOC), registered nurse (RN) and an employee of the home.

During the course of the inspection, the inspector: reviewed relevant documents including employee files, training records, staffing schedules, policies and procedures, clinical records and utilized the College of Nurses of Ontario (CNO) Find a Nurse website.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse (RN) who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times, except as provided for in the regulations.

Ontario Regulation 79/10 section 45, allows for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals. Park Lane Terrace does not qualify for any exceptions as specified in the regulations.

Park Lane Terrace is a long term care home with a licensed capacity of 132 beds.
The planned staffing pattern for RNs in the home, for the direct care of residents, is a minimum of one RN twenty-four hours a day, seven days a week, in addition to a combination of additional RNs on specified shifts, registered practical nurses and personal support workers to meet the nursing and personal care needs of residents, as identified by the DOC.
It was identified that the home was recently successful in recruiting a number of new staff to the nursing department to assist in meeting their planned staffing pattern.
In 2017, employee #200, was hired to the position of RN.
It was identified approximately one month later, that employee #200 did not have a certificate of registration with the CNO.
The Registered Nurse Staffing Schedule was reviewed for ten days in 2017.
This schedule identified that there were seven shifts, during this time period, that employee #200 worked at the home as the only RN present and on duty.
Interview with the DOC confirmed that on the identified seven shifts the home did not have a RN on duty and present at all times.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

Employee #200 was hired by the home in 2017, to the position of RN.
According to the Administrator and the DOC the employee was responsible for the direct care of residents, which included medication administration while they worked in the home in the position of RN.
The employee began to work, in the role of RN, in 2017, initially under the direct supervision of other RNs, for seven shifts and worked nine additional shifts, independently, as a member of the regular registered nursing staffing.
Approximately one month after hire, it was identified that the employee did not have a certificate of registration with the CNO, which was confirmed during an interview with the Administrator, DOC and the employee.
A review of the electronic medication administration records (eMAR) for residents #100, #101 and #102 for a specified period of time in 2017, identified that the employee administered medications, including but not limited to narcotics and other controlled substances and injections to the residents.

A person other than a physician, dentist, registered nurse or a registered practical nurse administered drugs to residents in the home. [s. 131. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Findings/Faits saillants :

1. The licensee failed to ensure that every member of the registered nursing staff (registered nurse, registered practical nurse, registered nurse in the extended class) had the appropriate current certificate of registration with the College of Nurses of Ontario (CNO).

Employee #200 was hired by the home in 2017, to the position of RN.
The employee began work, in the role of RN, initially under the direct supervision of other RNs, for seven shifts and worked nine additional shifts, independently, as a member of the regular registered nursing staffing.
Approximately one month after hire, during the course of an internal audit, it was identified that the home did not have a current certificate of registration with the CNO, for the employee.
A search was conducted on the CNO website "Find a Nurse" which did not include the employee; however, other registrants with the same name were listed on the website both as "entitled to practise with no restrictions" and "not entitled to practise".
Following discussions with the employee, DOC, Administrator and additional information provided by the CNO it was confirmed that the employee, did not have a certificate of registration with the CNO.
The employee was put on leave, awaiting their certificate of registration with the CNO.

Not every RN had a certificate of registration with the College of Nurses of Ontario. [s. 46.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications

Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,

(a) have the proper skills and qualifications to perform their duties; and

(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee failed to ensure that all staff of the home had the proper skills and qualifications to perform their duties and the qualifications provided for in the regulations.

The interpretation of "registered nurse" (RN) according to the LTCHA, 2007 identifies a RN as a member of the College of Nurses of Ontario (CNO) who holds a certificate of registration as a registered nurse under the Nursing Act 1991.

Ontario Regulation 79/10 section 46 identifies that the licensee shall ensure that every member of the staff who preforms duties in the capacity of registered nurse, registered practical nurse, or registered nurse in the extended class has the appropriate current certificate of registration with the CNO.

Employee #200 was hired by the home in 2017, to the position of RN.
According to the Administrator and the DOC, employee #200 was responsible for the direct care of residents while they worked in the home in the position of RN.
The employee began to work, in the role of RN, initially under the direct supervision of other RNs, for seven shifts and worked nine additional shifts, independently, as a member of the regular registered nursing staffing.
Approximately one month after hire, during the course of an internal audit, it was identified that the home did not have a certificate of registration with the CNO, for the employee.
A search was conducted of the CNO website "Find a Nurse" which did not include the employee.
Following discussions with the employee, DOC, Administrator and additional information provided by the CNO it was confirmed that the employee, did not have a certificate of registration with the CNO.

The employee did not have the qualifications to perform their duties nor the qualifications as provided for in the regulations. [s. 73.]

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 staff of the home have the proper skills and qualifications to perform their duties and the qualifications provided for in the regulations, to be implemented voluntarily.

Issued on this 15th day of August, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LISA VINK (168)

Inspection No. / No de l'inspection : 2017_556168_0026

Log No. / No de registre : 015089-17

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 15, 2017

Licensee / Titulaire de permis : PARK LANE TERRACE LIMITED
284 CENTRAL AVENUE, LONDON, ON, N6B-2C8

LTC Home / Foyer de SLD : PARK LANE TERRACE
295 GRAND RIVER STREET NORTH, PARIS, ON, N3L-2N9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Catherine Donahue

To PARK LANE TERRACE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that at least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times, except as provided for in the regulations.

The home shall ensure that all registered nurses who are an employee and part of the regular nursing staff of the home and on duty meet the definition of "registered nurse" in the LTCHA, 2007.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance.
The scope of the non-compliance is pattern (2), the severity of the non-compliance is minimal harm or potential for actual harm (2) and the history of non-compliance is a previous written notification (3).
This non-compliance was identified as a written notification in May 2017.

The licensee failed to ensure that there was at least one registered nurse (RN) who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times, except as provided for in the regulations.

Ontario Regulation 79/10 section 45, allows for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals. Park Lane Terrace does

not qualify for any exceptions as specified in the regulations.

Park Lane Terrace is a long term care home with a licensed capacity of 132 beds.
The planned staffing pattern for RNs in the home, for the direct care of residents, is a minimum of one RN twenty-four hours a day, seven days a week, in addition to a combination of additional RNs on specified shifts, registered practical nurses and personal support workers to meet the nursing and personal care needs of residents, as identified by the DOC.
It was identified that the home was recently successful in recruiting a number of new staff to the nursing department to assist in meeting their planned staffing pattern.
In 2017, employee #200, was hired to the position of RN.
It was identified approximately one month later, that employee #200 did not have a certificate of registration with the CNO.
The Registered Nurse Staffing Schedule was reviewed for ten days in 2017.
This schedule identified that there were seven shifts, during this time period, that employee #200 worked at the home as the only RN present and on duty.
Interview with the DOC confirmed that on the identified seven shifts the home did not have a RN on duty and present at all times.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times. [s. 8. (3)] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 25, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_556168_0029, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

The licensee shall ensure that all staff members working as a registered nurse or registered practical nurse and administering a drug to a resident meet the definition of "registered nurse" or "registered practical nurse" in the LTCHA, 2007.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance.
The scope of the non-compliance is isolated (1), the severity of the non-compliance is minimal harm or potential for actual harm (2) and the history of non-compliance is ongoing non-compliance (4). This non-compliance was served as a compliance order in May 2017.

The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

Employee #200 was hired by the home in 2017, to the position of RN.
According to the Administrator and the DOC the employee was responsible for the direct care of residents, which included medication administration while they worked in the home in the position of RN.
The employee began to work, in the role of RN, in 2017, initially under the direct supervision of other RNs, for seven shifts and worked nine additional shifts, independently, as a member of the regular registered nursing staffing.
Approximately one month after hire, it was identified that the employee did not have a certificate of registration with the CNO, which was confirmed during an interview with the Administrator, DOC and the employee.
A review of the electronic medication administration records (eMAR) for residents #100, #101 and #102 for a specified period of time in 2017, identified that the employee administered medications, including but not limited to narcotics and other controlled substances and injections to the residents.

A person other than a physician, dentist, registered nurse or a registered practical nurse administered drugs to residents in the home. [s. 131. (3)] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 25, 2017

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Order / Ordre :

The licensee shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario (CNO).

The licensee shall implement a process to ensure that before a staff member, performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class, that the individual has the appropriate current certificate of registration with the College of Nurses of Ontario (CNO).

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance.
The scope of the non-compliance is isolated (1), the severity of the non-compliance is minimal harm or potential for actual harm (2) and the history of non-compliance is ongoing non-compliance (4). This non-compliance was served as a compliance order in November 2016 and returned to compliance in June 2017.

The licensee failed to ensure that every member of the registered nursing staff (registered nurse, registered practical nurse, registered nurse in the extended class) had the appropriate current certificate of registration with the College of Nurses of Ontario (CNO).

Employee #200 was hired by the home in 2017, to the position of RN.
The employee began work, in the role of RN, initially under the direct supervision of other RNs, for seven shifts and worked nine additional shifts, independently, as a member of the regular registered nursing staffing.
Approximately one month after hire, during the course of an internal audit, it was identified that the home did not have a current certificate of registration with the CNO, for the employee.
A search was conducted on the CNO website "Find a Nurse" which did not include the employee; however, other registrants with the same name were listed on the website both as "entitled to practise with no restrictions" and "not entitled to practise".
Following discussions with the employee, DOC, Administrator and additional information provided by the CNO it was confirmed that the employee, did not have a certificate of registration with the CNO.
The employee was put on leave, awaiting their certificate of registration with the CNO.

Not every RN had a certificate of registration with the College of Nurses of Ontario. [s. 46.] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 25, 2017

REVIEW/APPEAL 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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15th day of August, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LISA VINK

Service Area Office / Bureau régional de services : Hamilton Service Area Office