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 prévue le Loi de 2007 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 soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 16, 2018;	2017_689586_0013 (A1)	027590-17	Resident Quality Inspection

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

Ontario

Ministry of Health and Long-Term Care

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

JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Change to date in CO #003.
Rescind non-compliance related to s. 101.

Issued on this 16 day of February 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 6, 7, 8, 12, 13 and 14, 2017.

The following Complaint Inspections were completed concurrently with the RQI:

010738-17 - Personal Support Services, Housekeeping; and,

011774-17 - Medication Management.

The following Critical Incident System (CIS) Inspection was completed concurrently with the RQI:

015875-17 - Falls Prevention & Management.

The following Follow Up Inspections were completed concurrently with the RQI:

012653-17 - Transferring & Positioning;

012655-17 - Falls Prevention & Management;

012657-17 - Plan of Care;

017031-17 - Continence Product Charges;

019302-17 - Certification of Nurses;

019304-17 - 24/7 RN;

019306-17 - Administration of Drugs; and,

019408-17 - Skin & Wound.

The following on-site Inquiries were conducted concurrently with the RQI:

025747-17 - Trust Accounts; and,

011544-17 - Oral Care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Clinical Services (DCS), Associate Director of Clinical Services (ADCS), Director of Programs and Support Services (DPSS), Director of Business Services (DBS), Resident Assessment Instrument (RAI) Co-ordinator, Admissions Co-ordinator, Clinical Services Managers, Registered Dietitian (RD), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services and reviewed relevant documents including but not limited to clinical health care records, policies and procedures, staff schedules and plans, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
5 VPC(s)
3 CO(s)
1 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (3)	CO #002	2017_556168_0026	168
O.Reg 79/10 s. 36.	CO #001	2017_556168_0006	168
O.Reg 79/10 s. 46.	CO #003	2017_556168_0026	168
O.Reg 79/10 s. 49. (2)	CO #002	2017_556168_0006	168
LTCHA, 2007 s. 6. (10)	CO #003	2017_556168_0006	168

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

The clinical record identified that in July 2017, resident #040 had an area of altered skin integrity, which staff assessed and recorded their finding in the clinical record on a "Weekly Wound Assessment". The resident was transported to the hospital following an incident that resulted in injury four days after the most recent Weekly Wound Assessment was completed, according to the clinical record and a critical incident report. The resident returned from the hospital the day following the incident.

A review of the clinical record did not include a skin assessment on the resident's return from hospital. The record included a completed "Braden" assessment, which was used to predict risk of pressure sores, which identified the resident at high risk, the day following their return from hospital. Interview with the DCS verified that a skin assessment was not completed on return from hospital; however, a Braden was completed, by RN #112 instead, in error. [s. 50. (2) (a) (ii)]

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 LTCHA, 2007, 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 who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

Note: In this section "regular nursing staff" means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals

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, was two RNs on the day shift five days a week and one RN on the day shift two days a week; and one RN on both the evening and night shifts seven days a week. The home also utilized a mix of RPNs and PSWs to meet the nursing and personal care needs of residents, as identified by the schedule.

Interview with the DCS identified that the home had recently been successful in recruitment of additional RNs and RPNs and that they do have a sufficient number of staff to fill all required shifts in the staffing plan; however, recently due to staff illness, there were occasions where the home had vacant RN shifts to fill.

It was identified that the home took measures to fill the required shifts including overtime and reassignment of hours and duties; however, when the RNs employed by the home were unwilling or unable to work a vacant shift the home filled the shift with an RN employed by an employment agency to ensure that there was an RN onsite 24 hours a day, seven days a week.

A review of the RN schedules over a three and a half month period in 2017, and Daily Assignment Sheets, identified 11 occasions on the evening or night shifts, where the only RN in the building was an agency RN, as confirmed by Clinical Service Coordinator. The agency RNs were not members of the regular nursing staff. [s. 8. (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 LTCHA, 2007, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91(1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006 including goods and services funded by a local health integration network under a service accountability agreement, and ii. The Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCHA) Policy, LTCHA Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the

accommodation charge payable under the Long Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

Section 51(2) of the Regulation under the LTCHA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible and (v) are appropriate for the time of day, and for the individual resident's type of incontinence".

If a resident was assessed to require a specified type of incontinent product then it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee permitted the resident's representative to make a charge or accept a payment on the licensee's behalf for continence care products, which they received funding from the local health integration network under the service accountability agreement.

The home submitted a plan to the Ministry of Health and Long Term Care (MOHLTC) on July 11, 2017, related to CO #001, s. 91. (4) which indicated that a resident list was compiled of all residents that resided in the home from July 1, 2010 to April 2017, including the residents identified on the compliance order. They reviewed documentation which included initial assessments and care plans to confirm accuracy of the assessed usage and need of continence products at the time of admission and throughout residency. The audit was used to determine if other residents that were not included on the original audit were charged for specified continence products and they were reimbursed as required. A spreadsheet was created that identified the resident's name, contact information for

resident, Power of Attorney (POA) or Substitute Decision-Maker (SDM), continence assessment status related to whether the resident wore the specified continence product and reimbursement provided in order to provide thorough documentation of the audit completed.

Review of the audit and the spreadsheet that the home provided to inspector revealed the following:

i. The audit listed 366 residents that had resided in the home since July 1, 2010 and identified whether they wore a specified continence product which was paid for by the resident and/or family. The audit identified that 35 residents wore a specified continence product and the product was paid for by residents/families.
ii. The home documented the 35 residents on a spreadsheet which included, but was not limited to their contacts, the admission and discharge date for each of these residents, how many months each resident resided in the home and identified that each resident on average would use a box of specified products a month and multiplied the number of months the resident resided in the home by the average cost of a box of the specified product, 58.00 dollars ($) and reimbursed 31 residents/families that total amount. A separate audit was completed by the home after the original Compliance Order was served (Inspection Report #2016_343585_0007); at which time four additional residents were reimbursed and according to the current audit did not have a balance owed.
iii. Review of the spreadsheet the home provided revealed that 35 of the initial 38 residents identified on the first audit were identical on the current audit and listed three residents not included in the current audit as not using the specified continence products while residing in the home.

A) Review of the written plan of care for resident #042 identified they wore a specified continence product and they were supplied by their family.

B) Review of the written plan of care for resident #049 revealed that the family purchased a specified continence product for them, staff were to notify the family when they were getting low and they would purchase more.

C) Review of the written plan of care for resident #050 identified the resident wore specified continence products and their family purchased them.

Review of the home's audit and spreadsheet provided to the inspector during the course of this inspection did not identify resident #042, #049 and #050 as wearing

the specified products and therefore the resident/families were not reimbursed for the products they purchased while the residents resided in the home.

Interview and review of the clinical health records with the ED stated that the three residents did wear the specified continence products, were not identified on the home's audit as wearing the products and confirmed the residents/families were not reimbursed for the products they paid for.

D) Review of the written plan of care for resident #051 revealed they wore the specified continence products (if available); however, they were not on the audit list as residing in the home and wearing the products. Interview with the ED confirmed the resident did reside in the home, was not listed on the home's audit and spreadsheet and was not reimbursed for the products purchased by the resident/family.

E) Review of the home's current audit, identified that resident #055 did not wear the specified continence products; however, the resident was identified on the previous Follow-up Compliance Order (Inspection Report # 2017_573581_0004) which identified the family was billed for pull up products purchased from a supplier. Review of the current audit with the ED confirmed that resident #055 was identified as not wearing the specified continence products and therefore the resident/family did not receive reimbursement from the home for the products they were charged for from the supplier.

F) Review of the home's current audit revealed that resident #056 used a specified continent product, and indicated that they resided in the home for 12 months; however, the clinical record identified that they were in the home for much longer than that. Telephone interview with the Corporate Representative confirmed that an error was made on the current audit which impacted the reimbursement amount and that the home would correct the error and provided additional reimbursement to the resident as required.

G) Review of the first audit the home completed identified that resident #053 wore specified continence products. Review of the current audit the home provided to the inspector did not include the resident as wearing the specified continence product. Review of the resident's written plan of care identified that the resident was using a different type of product until the specified product was received. Interview with the ED stated the resident was on the current audit as not wearing the specified product but was identified as wearing them when they completed

another audit of all discharged residents while the inspectors were in the home.

Interview with the ED stated they reviewed all discharged resident's written plans of care on December 13, 2017, and they identified that an additional 30 residents including residents #042, #049, #050 and #051 were revealed as wearing the specified continence products which the families purchased and were not identified on the current home's audit. The ED provided LTCH Inspector with another document that they created with a list of the newly identified 30 resident's names including the four residents identified above. The ED stated that they created a different tool to determine how to reimburse the residents/families who were not on the first spreadsheet for the continence products that they purchased. They informed the LTC Inspector that they counted the number of days that the residents were in the home and divided that by one quarter as the home was now going to estimate that the residents wore the continence products for 25 percent of the time they resided in the home and divided the $58.00 per month for a box of continence products to a daily amount of $1.90 and stated the home would now pay these residents/families the daily amount times one quarter of the number of days they resided in the home.

The ED stated they would also audit all of the current residents residing in the home to ensure that they were not paying for the product during the specified time period.

After reviewing the current audit and additional document with the ED they confirmed that the audit was inaccurate and did not include all the residents that wore the specified continence products which the resident/family paid for while residing in the home.

The home failed to ensure that when a resident was assessed to require the specified incontinent product between June 2010 and July 2017, that all residents were included in the audit, all residents and families were contacted and informed that the home would be reimbursing them for the specified products they had paid for independently. That all residents/families were reimbursed for the total cost of the specified products that they incurred regardless if the residents/SDM or the estate provided receipts. [s. 91. (4)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy, "Head Injury Routine" (HIR), (effective date January 2014), directed registered staff following a resident fall, where the resident had hit their head and following any injury to the head the process noted below would be initiated including but not limited to, the neurological vital signs would be initiated and recorded in Point Click Care (PCC). Once the first neurological check had been saved, signed and locked, this would trigger the next time frame to complete the next assessment and the times for completion were every 30 minutes for two hours, every hour for six hours, every four hours for 16 hours and every eight hours for 48 hours.

On an identified date in 2017, resident #040 had an unwitnessed fall resulting in transfer to hospital and a significant injury. Review of the plan of care identified that the neurological vital signs was not initiated and recorded in PCC. Interview with DCS stated that when a resident had an unwitnessed fall or a fall where they hit their head, registered staff were to complete neurological vital signs and document in PCC. They confirmed that the HIR was not completed consistently for resident #040 after the fall or after they returned for hospital for the next 48 hours and that the home's HIR policy was not complied with. (581).

B) The home's policy, 'Falls Prevention and Protocol' (effective date March 2014) directed staff to, when a resident experienced a fall, document the fall as an incident in the Point-Click Care (PCC) Risk Management Report and to complete a post-fall assessment and a pain assessment "as well".

In an interview with the DCS on December 12, 2017, they indicated that the post-fall assessment consisted of both of the Falls Risk Assessment and the Post Fall Audit Tool.

Resident #001 fell on an identified date in 2017. A review of the clinical record did not include the post-fall assessment following the fall as confirmed by the DCS, as the Falls Risk Assessment and the Post Fall Audit Tool had not been completed. The home's falls policy was not complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that alternatives to the use of a personal assistance services device (PASD) under subsection (3) had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living.

A) On an identified date in 2017, resident #006 was observed with an identified PASD applied. Review of the plan of care identified they required the PASD. A review of the resident's health record did not include an assessment for the use of the PASD that included any information on alternatives that had been considered or tried. Interview with RN #110 stated the resident had the PASD applied and confirmed that alternatives to the use of the PASD had not been considered and tried. (581).

B) Resident #009's documented plan of care included the use of two identified PASDs with restraining effects. The resident was observed throughout the RQI with these applied. A review of the resident's health record did not include an assessment for the use of the PASDs, nor any information on alternatives that had been considered or tried. This was confirmed by RN #110 on December 12, 2017. [s. 33. (4) 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 alternatives to the use of a personal assistance services device (PASD) under subsection (3) have been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act, was applied by staff in accordance with any manufacturer's instructions.

On an identified date in 2017, resident #002 was observed using a mobility device with a PASD inappropriately applied. Review of the plan of care identified they required the PASD. Interview with RN #105 verified that the PASD was not appropriately applied, confirmed the appropriate application, and acknowledged that the PASD was not applied according to manufacturer's instructions.

The DCS was not able to provide manufacturer's instruction for the application of the specified type of PASD despite attempts including contacting the vendor. The DCS was shown by the LTC Inspector written instructions related to the application of the specified PASD. Upon review of the document confirmed this was the information that was communicated to staff as part of application training in the home. The DCS took a photo copy of the document and identified they would maintain this document for reference. [s. 111. (2) (b)]

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 a PASD used under section 33 of the Act, is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On request the home provided medication incidents for a three month period of time in 2017. A review of the medication incident reports identified that not all incidents included a record of the immediate actions taken to assess and maintain the resident's health as well as reported to all of the required parties.

i. Resident #062 was involved in a medication incident in 2017, which was identified and reported at a later date. A review of the clinical record, around the time of the incident and the medication incident report did not include a record of the immediate actions taken to assess and maintain the resident's health, nor that the incident was reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident or the pharmacy service provider, as confirmed by the DCS.

ii. Resident #063 was involved in a medication incident in 2017, which was identified and reported at a later adate. A review of the clinical record, around the time of the incident and the medication incident report did not include that a physician or the registered nurse in the extended class attending the resident was notified of the incident, as confirmed by the DCS. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff consistently participated in the implementation of the infection prevention and control program.

The home has a procedure, "Infection Prevention and Control - Additional Precautions" (effective date January 2014). This procedure identified that "additional precautions used are determined by the modes of transmission in which the infective organism is spread (if known) and the clinical symptoms of the resident", including contact specific precautions; and that "it is important that necessary IPAC (infection prevention and control) precautions be communicated to staff, support services staff and others in a manner that effective informed those with a need to know while respecting an infected resident's privacy, dignity and right to confidentiality".

On two dates during the RQI, the door outside of resident's #038 and #039 room included IPAC signage which identified specified precautions and displayed pictures of hand washing, a gown, gloves, a mask and face shield. A review of a cart outside of the room included gowns, gloves and plastic bags only.

Interview with RN #102 identified that when signage is posted related to additional precautions staff are to use the personal protective equipment as identified on the sign and that the supplies should be readily available in the cart outside of the residents' room. RN #102 indicated that resident #039 was on precautions due to a diagnosis. They were informed by the LTCH Inspector that the signage posted was for droplet/contact precautions and displayed pictures of hand washing, a gown, gloves, a mask and face shield. They identified that the resident was on only one type of precaution and not the other and that the signage was not accurate. [s. 229. (4)]

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 staff consistently participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident, the goals the care was intended to achieve, and clear directions to staff and others who provided direct care to the resident.

A) Resident #020 had a physician's order for a treatment. Review of the resident's documented plan of care, which front line staff use to direct care, did not include

the treatment. In an interview with RPN #120 on December 13, 2017, they confirmed the resident's treatment and indicated that this information should have been in the documented plan of care. The written plan of care did not set out the planned care for resident #020.

B) Resident #020 required a certain level of assistance for transferring. Their SDM voiced concern to the LTC Inspector that, at times, the resident was left in their mobility device for extended periods of time and was not consistently laid down in bed for rest periods during the day. In an interview with RPN #120, they verified that the resident had a specific rest period schedule. A review of the resident's health record did not include any information around the resident's rest routine or rest period schedule. The written plan of care did not set out the planned care for resident #020.

C) Resident #020's health record demonstrated that on multiple occasions, the resident had issues that required oral care. The Medication Administration Record (MAR) was updated by RPN #120, directing staff to use a specified type of oral care product to assist the resident when they were experiencing the issue. The RPN confirmed on December 13, 2017, that this direction was for registered staff, and that PSWs were still required to complete regular mouth care.

A review of the resident's health record included direction for regular oral care, but did not include any further information or clear direction for staff on the resident's oral care needs. Resident #020's written plan of care did not provide clear directions to staff and others who provided direct are to the resident. [s. 6. (1)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

Review of the plan of care for resident #040 identified they fell and sustained a significant injury on an identified date in 2017. Review of the MDS assessment did not indicate they had a fall in the past 31-180 days and a specific type of injury in the last 180 days. Interview and review of the clinical health record with RN #102 stated the resident did fall and sustain a specific type of injury as evidenced by a hospital report and confirmed that the MDS assessments and the hospital report were not integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care collaborated with each other, in the development and implementation of the plan of care so that different aspects of care were integrated and were consistent with and complemented each other.

On an identified date in 2017, resident #006 was observed wearing a specified type of visual appliance. Review of the MDS assessment identified they had impaired vision. Review of the Resident Assessment Protocol (RAP) from the following assessment identified that they wore the visual appliance most of the time due to a specific diagnosis. Review of the written plan of care documented that the resident wore the prescription visual appliance for impaired vision. Interview with PSW # 111 and RN #110 stated that the resident only wore a non-prescription visual appliance and none other. RN #110 confirmed that the MDS assessment, RAP and the written plan of care were not integrated and consistent with each other. [s. 6. (4) (b)]

4. The licensee failed to ensure that care was provided to the resident as specified in the plan of care.

Resident #003 was at an identified nutritional risk and required the use of two adaptive devices at their meals, as indicated in their documented plan of care, as well as the diet list located in the servery. Observation of the resident during breakfast meal service in the dining room on two occasions during the RQI identified that the resident did not receive the adaptive devices to assist with their independence in eating. Resident #003 was not provided care as specified in their plan of care. [s. 6. (7)]

(A1)
The following Non-Compliance has been Revoked: WN #10

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Issued on this 16 day of February 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère 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 153 et/ou 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

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
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA PALADINO (586) - (A1)

Inspection No. / No de l'inspection : 2017_689586_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 027590-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 16, 2018;(A1)

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 : Mike Schmidt

Ontario

Ministry of Health and Long-Term Care

Ministère 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 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2017_555506_0009, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

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 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that a resident at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

The plan should be submitted via email by March 1, 2018, to Jessica Paladino via e-mail at HamiltonSAO.MOH@ontario.ca.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the potential for harm toward resident #040, the scope of one isolated incident, and the Licensee's history of non-compliance (CO) on the February 2017 Critical Incident System (CIS) Inspection with the r. 50. (2) (a) (ii) related to resident skin assessments.

The licensee failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

The clinical record identified that in July 2017, resident #040 had an area of altered skin integrity, which staff assessed and recorded their finding in the clinical record on a "Weekly Wound Assessment". The resident was transported to the hospital following an incident that resulted in injury four days after the most recent Weekly Wound Assessment was completed, according to the clinical record and a critical incident report. The resident returned from the hospital the day following the incident.

A review of the clinical record did not include a skin assessment on the resident's return from hospital. The record included a completed "Braden" assessment, which was used to predict risk of pressure sores, which identified the resident at high risk, the day following their return from hospital. Interview with the DCS verified that a skin assessment was not completed on return from hospital; however, a Braden was completed, by RN #112 instead, in error. (581)

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

Apr 01, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_556168_0026, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 a Registered Nurse (RN), who is an employee of the home, is scheduled to work in the home and on duty and present at all times except as provided for in the regulations.

To achieve this requirement the licensee shall develop written strategies to recruit, hire and retain RNs, who will hold the position of an employee of the licensee and a member of the regular nursing staff, and implement the strategies to an effort to ensure coverage of vacation relief and sick or absent calls for regular RNs.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s. 299(1) of the Regulation, in respect of the risk of harm toward the residents of the home, the scope of a pattern of incidences, and the Licensee's history of non-compliance (VPC) on the February 3, 2015, RQI and (CO) on the August 2017 CIS Inspection with the s. 8 (3) related to the use of 24/7 RN coverage.

The licensee failed to 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 unless there was an allowable exception to this requirement.

Note: In this section "regular nursing staff" means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals

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, was two RNs on the day shift five days a week and one RN on the day shift two days a week; and one RN on both the evening and night shifts seven days a week. The home also utilized a mix of RPNs and PSWs to meet the nursing and personal care needs of residents, as identified by the schedule.

Interview with the DCS identified that the home had recently been successful in recruitment of additional RNs and RPNs and that they do have a sufficient number of staff to fill all required shifts in the staffing plan; however, recently due to staff illness, there were occasions where the home had vacant RN shifts to fill.

It was identified that the home took measures to fill the required shifts including overtime and reassignment of hours and duties; however, when the RNs employed by the home were unwilling or unable to work a vacant shift the home filled the shift with an RN employed by an employment agency to ensure that there was an RN onsite 24 hours a day, seven days a week.

A review of the RN schedules over a three and a half month period in 2017, and Daily Assignment Sheets, identified 11 occasions on the evening or night shifts, where the only RN in the building was an agency RN, as confirmed by Clinical Service Coordinator. The agency RNs were not members of the regular nursing staff. (168)

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

Mar 13, 2018

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_573581_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan to ensure that all current and former residents since July 1, 2010, to present will be reimbursed for the total cost incurred for the specified style of continence care products, that should have been provided at no charge, while the resident resided in the home.

The plan shall include:

1. Development and implementation of an audit that includes the 30 residents that were identified on the spreadsheet developed by the Executive Director on December 13, 2017, and any other residents not previously identified on the home's audit. The home will review the following documents, including but not limited to, residents' written plans of care, bowel and bladder continence assessments, admission assessments, Resident Assessment Protocols (RAP), and billings from medical or continence care product suppliers. The home shall identify and document the specific length of usage of the specified continent products for the above identified 30 residents, in addition to any residents further identified from the audit, to determine the reimbursement required for each resident. If the

home is unable to identify the specific length of usage for the specified continent product, then they shall reimburse resident/SDM/POA for the entire time the resident resided in the home, as they did in response to the previous compliance order # 2017_573581_0004.

2. Development of a plan for reimbursement for all residents who utilized and were charged for or purchased the specified products during the course of their residency at Park Lane Terrace from July 2010 to present. In the absence of a receipt the home is to estimate the average usage of the product, per resident, per day as determined by a review of relevant documents as required above, and refund the resident/SDM/POA for the incurred cost.

3. Development of a system to ensure that all decision-makers of residents in the past six years, that were assessed to require the specified products, are contacted and informed that they will be receiving reimbursement for costs that they incurred for purchasing the specified products while the resident resided in the home.

4. Development and implementation of a schedule for reimbursement for the current and former residents/SDM/POA for the full cost of the products used during their length of stay by March 31, 2018.

The plan should be submitted via email by March 13, 2018, to Jessica Paladino via e-mail at HamiltonSAO.moh@ontario.ca.

Grounds / Motifs :

(A1)
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 noncompliance is isolated (1), the severity of the non-compliance has minimal risk (1) and the history of multiple non-compliances (5) with compliance orders issued previously in May 2016 and June 2017.

The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91(1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006 including goods and services funded by a local health integration network under a service accountability agreement, and ii. The Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCHA) Policy, LTCHA Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

Section 51(2) of the Regulation under the LTCHA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible and (v) are appropriate for the time of day, and for the individual resident's type of incontinence".

If a resident was assessed to require a specified style incontinent product then it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee permitted the resident's representative to make a charge or accept a payment on the licensee's behalf for continence care products, which they received funding from the local health integration network under the service accountability agreement.

The home submitted a plan to the Ministry of Health and Long Term Care (MOHLTC) on July 11, 2017, related to CO #001, s. 91. (4) which indicated that a resident list was compiled of all residents that resided in the home from July 1, 2010 to April 2017, including the residents identified on the compliance order. They reviewed documentation which included initial assessments and care plans to confirm accuracy of the assessed usage and need of continence products at the time of admission and throughout residency. The audit was used to determine if other residents that were not included on the original audit were charged for the specified continence products and they were reimbursed as required. A spreadsheet was created that identified the resident's name, contact information for resident, Power of Attorney (POA) or Substitute Decision-Maker (SDM), continence assessment status related to whether the resident wore the specified continence product and reimbursement provided in order to provide thorough documentation of the audit completed.

Review of the audit and the spreadsheet that the home provided to inspector revealed the following:

i. The audit listed 366 residents that had resided in the home since July 1, 2010 and identified whether they wore the specified style continence product which was paid for by the resident and/or family. The audit identified that 35 residents wore the specified continence product and the product was paid for by residents/families.
ii. The home documented the 35 residents on a spreadsheet which included, but was not limited to their contacts, the admission and discharge date for each of these residents, how many months each resident resided in the home and identified that each resident on average would use a box of the specified products a month and multiplied the number of months the resident resided in the home by the average cost of a box, 58.00 dollars ($) and reimbursed 31 residents/families that total amount. A separate audit was completed by the home after the original Compliance

Order was served (Inspection Report #2016_343585_0007); at which time four additional residents were reimbursed and according to the current audit did not have a balance owed.
iii. Review of the spreadsheet the home provided revealed that 35 of the initial 38 residents identified on the first audit were identical on the current audit and listed three residents not included in the current audit as not using the specified style continence products while residing in the home.

A) Review of the written plan of care for resident #042 identified they wore the specified continence product and they were supplied by their family.

B) Review of the written plan of care for resident #049 revealed that the family purchased the specified for them, staff were to notify the family when they were getting low and they would purchase more.

C) Review of the written plan of care for resident #050 identified the resident wore the specified continence products and their family purchased them.

Review of the home's audit and spreadsheet provided to the inspector during the course of this inspection did not identify resident #042, #049 and #050 as wearing the specified products and therefore the resident/families were not reimbursed for the specified products they purchased while the residents resided in the home.

Interview and review of the clinical health records with the ED stated that the three residents did wear the specified continence products, were not identified on the home's audit as wearing the specified products and confirmed the residents/families were not reimbursed for the specified products they paid for.

D) Review of the written plan of care for resident #051 revealed they wore the specified product (if available); however, they were not on the audit list as residing in the home and wearing the specified products. Interview with the ED confirmed the resident did reside in the home, was not listed on the home's audit and spreadsheet and was not reimbursed for the specified products purchased by the resident/family.

E) Review of the home's current audit, identified that resident #055 did not wear the specified continence products; however, the resident was identified on the previous Follow-up Compliance Order (Inspection Report # 2017_573581_0004) which identified the family was billed $1269.17 for the specified products purchased from a

specific vendor. Review of the current audit with the ED confirmed that resident #055 was identified as not wearing the specified continence products and therefore the resident/family did not receive reimbursement from the home for the specified products they were charged for from the vendor.

F) Review of the home's current audit revealed that resident #056 used the specified continent product. They were in the home for 12 months and that the resident was reimbursed for the use of the continent product during this time. A review of the clinical record identified that the resident was admitted in 2012 and discharged in 2015, and resided in the home for approximately 28 months. Telephone interview with the Corporate Representative confirmed that an error was made on the current audit which impacted the reimbursement amount and that the home would correct the error and provided additional reimbursement to the resident as required.

G) Review of the first audit the home completed identified that resident #053 wore the specified continence products. Review of the current audit the home provided to the inspector did not include the resident as wearing the specified continence product. Review of the resident's written plan of care identified that the resident was using a different type of product at present until supply of the specified product was received. Interview with the ED stated the resident was on the current audit as not wearing the specified product but was identified as wearing them when they completed another audit of all discharged residents while the inspectors were in the home.

Interview with the ED stated they reviewed all discharged resident's written plans of care on December 13, 2017, and they identified that an additional 30 residents including residents #042, #049, #050 and #051 were revealed as wearing the specified continence products which the families purchased and were not identified on the current home's audit. The ED provided LTCH Inspector with another document that they created with a list of the newly identified 30 resident's names including the four residents identified above. The ED stated that they created a different tool to determine how to reimburse the residents/families who were not on the first spreadsheet for the specified continence products that they purchased. They informed the LTC Inspector that they counted the number of days that the residents were in the home and divided that by one quarter as the home was now going to estimate that the residents wore the specified product for 25 percent of the time they resided in the home and divided the $58.00 per month for a box of the specified product to a daily amount of $1.90 and stated the home would now pay these

residents/families the daily amount times one quarter of the number of days they resided in the home.

The ED stated they would also audit all of the current residents residing in the home to ensure that they were not paying for the specified product during the specified time period.

After reviewing the current audit and additional document with the ED they confirmed that the audit was inaccurate and did not include all the residents that wore the specified products which the resident/family paid for while residing in the home.

The home failed to ensure that when a resident was assessed to require a the specified style of incontinent product between June 2010 and July 2017, that all residents were included in the audit, all residents and families were contacted and informed that the home would be reimbursing them for the specified products they had paid for independently. That all residents/families were reimbursed for the total cost of the specified products that they incurred regardless if the residents/SDM or the estate provided receipts. (586)

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

May 11, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

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 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16 day of February 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA PALADINO - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère 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

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Service Area Office / Bureau régional de services : Hamilton