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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2019	2019_570528_0010	001855-19, 001859-19	Follow up

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

CYNTHIA DITOMASSO (528), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 13, 14, 15, 18 and 19, 2019.

This follow up inspection included:
Log #001855-19, related to CO #007 (#2018_695156_0006) for Ontario Regulation 79/10 s. 71(3) menu planning and,
Log #001859-19, related to CO #003 (#2018_695156_0006) for Ontario Regulation 79/10 s. 33(1) bathing.

This inspection was conducted concurrently with Critical Incident Inspection #2019_560632_0008.

LTC Home Inspector #748, Emmy Hartmann was also present during the inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Scheduling Coordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documents including but not limited to, clinical health records, bathing schedules, menus, staffing schedules, education records, job routines, policies and procedures.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services

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

5 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.

0 AMP(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. 33. (1)	CO #003	2018_695156_0006	528
O.Reg 79/10 s. 71. (3)	CO #007	2018_695156_0006	632

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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD (personal assistance services device) described in subsection (1) that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

A. In March 2019, resident #111 was observed seated in their wheelchair by the nursing station with a safety device applied.
i. Review of the plan of care did not include any documentation of the device, including, an assessment or consent.
ii. Interview with RPN #120 in March 2019, confirmed that the resident required the device daily to assist with activities of daily living and that the resident could not release themselves from the PASD. Interview with RPN #112 confirmed that the plan of care did not include the use of the device with activities of daily living. (528)

B. In March 2019, resident #128 was observed seated in their wheelchair with a safety device applied, which they were unable to release.
i. Review of the plan of care did not include any documentation of the device, including, an assessment or consent.
ii. Interview with RPN #120 in March 2019, confirmed that the resident required the device daily to assist with activities of daily living and that the resident could not release themselves from the PASD. Interview with RPN #112 confirmed that the plan of care did not include the use of the device with activities of daily living. (528)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care, to be implemented voluntarily.

WN #2: 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 the PASD used under section 33 of the Act was applied by staff in accordance with the manufacturer's instructions (if any).

A. In March 2019, resident #111 was observed seated in their wheelchair by the nursing station with a device, which was not applied according to manufacturer's instructions. Interview with RPN #120 in March 2019, confirmed that the resident required the device daily to assist with activities of daily living and that the resident could not release themselves from the device. RPN #120 also confirmed that the device was not applied in accordance with manufacturer's instructions.

B. In March 2019, resident #127 was observed seated in their wheelchair with a safety device applied not according to manufacturer's instructions.
ii. Interview with the resident confirmed that they were unable to physically or cognitively release themselves from the device.
iii. Interview with RPN #120 in March 2019, confirmed that the resident required the device daily to assist with activities of daily living and that the resident could not release themselves from the PASD. RPN #120 also confirmed that the device was not applied in accordance with manufacturer's instructions. (528)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the PASD used under section 33 of the Act is applied by staff in accordance with the manufacturer's instructions (if any), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of special treatments and interventions with respect to the resident.

A. In March 2019, resident #093 was observed and interventions were not provided to the resident.
i. In March 2019, PSW #101 stated that the resident had a change in condition and did not have an intervention. Inspector #632 and PSW #101 reviewed the resident's current interventions by referring to the current written plan of care saved in Point of Care (POC) and no special considerations or restrictions were noted for providing care for the resident's daily activities. In March 2019, RPN #103 stated that resident #093 had a change in condition and a nutritional intervention was offered to the resident.
ii. Progress notes review identified that in March 2019, the resident's family agreed that the resident had a change in treatment plan and required a change in medication orders. A referral to the registered dietician (RD) noted that the resident had a change in condition. In March 2019, the ED indicated that KARDEX in POC contained the details of the resident's care that supported daily tasks. In March 2019, RPN #108 indicated that there were no specific recommendations for activities of daily living (ADL).
iii. Review of the residents' written plan of care did not contain any specific interventions for activities of daily living related to the resident's change in condition, which was acknowledged by the ED in March 2019.

B. Review of resident #118's written plan of care did not contain any specific interventions, for a change in condition in relation to eating or any other areas of ADL.
i. Progress notes review indicated that resident #118's family agreed that the resident had a change in condition.
ii. In March 2019, the ED indicated that KARDEX in POC contained the details of the resident's care that supported by tasks, and did not include any specific interventions related to the resident's change in condition.

C. Review of resident #122's written plan of care did not contain any specific interventions, for a change in condition in relation to eating or any other areas of ADL.
i. Progress notes review indicated that resident #122 had a change in condition.
ii. In March 2019, the ED indicated that KARDEX in POC contained the details of the resident's care that supported tasks, and did not include any specific interventions related to the resident's change in condition.

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 plan of care is, based on, at a minimum, interdisciplinary assessment of special treatments and interventions with respect to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Section 8 (1) of the Act, outlines the requirement for nursing and personal support services, including but not limited to, an organized program of personal support services for the home to meet the assessed needs of the residents.

A. Follow Up log #001859-19 was reviewed for Compliance Order #003 issued in January 2019, which directed the home to ensure that all residents were bathed, at a minimum, of twice per week by the method of his or her choice and more frequently as determined by the resident's requirements, unless contraindicated by a medical condition. Compliance date for the order was February 2019.
Review of clinical health records related to bathing for the residents specified in the compliance order from February 2019, identified that 12 residents had documentation missing related to their scheduled bathing.

B. Review of the home's policy and procedures (effective October 2018), "ROUTINES DAY SHIFT", "ROUTINES PSW SPLIT BATH SHIFT", "ROUTINES PSW SHORT SHIFT", "ROUTINES PSW EVENING SHIFT" and "ROUTINE PSW BATH EVENING SHIFT", included bathing as PSW tasks, at identified times, and directed PSW staff to document in Point of Care (POC).

C. The bathing schedule for resident #007 identified that they were bathed twice a week by a PSW who worked the bath evening shift. Review of POC documentation from February 2019, revealed that bathing was not documented on two occasions. In March 2019, PSW #115 and PSW #119 were interviewed and confirmed they worked on both identified days and that the resident was bathed; however, the baths were not documented in POC, as required.

D. The bathing schedule for resident #107 identified that they were bathed twice a week by a PSW who worked the bath evening shift. Review of POC documentation from February 2019, revealed that bathing was not documented on three occasions. Interview with PSW #115 and #118 in March 2019, confirmed that the resident had been bathed according to their schedule, no baths were missed, but had not been documented in POC.

E. The bathing schedule for resident #004 identified that they were bathed twice a week by a PSW who worked the bath evening shift. Review of POC documentation from February 2019, revealed that bathing was not documented on two occasions. Interview with PSW #119 in March 2019, confirmed that bathing was completed for the assigned resident; however, they had not documented in POC.

F. Interview with the Scheduling Coordinator in March 2019, revealed that the home was having issues with PSW staff documenting that resident's baths were completed. Interview with RN #126 confirmed that bathing audits revealed that PSW staff were not consistently documenting bathing in POC.

G. Interview with Scheduling Coordinator, DOC, and the Executive Director in March 2019, identified that the home had created a new process to address missed scheduled baths, by using a bathing tracking tool to scheduling additional staff. In addition, the homes internal auditing of the new missed bathing tracking, revealed that the electronic documentation was inaccurate and not reflective of the residents' care, related to bathing. In the interview, the ED outlined a new process, effective March 2019, where bathing documentation would be completed on paper, and that information and education to staff

would be included; however, prior to the effective date the expectation of PSW staff would be that bathing had been documented in POC.

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

In March 2019, during breakfast service, a medication cart was noted outside the dining room, unlocked, and not visible by the registered staff. RPN #103 was observed walking into the dining room and then left to use the phone. When RPN #103 returned, they confirmed that they had made a mistake and that the cart should be locked at all times when unattended, as required.

Issued on this 15th day of April, 2019

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

Original report signed by the inspector.