Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 15, 2019	2019_570528_0016	024694-18, 025615-18, 026242-18, 027156-18, 028483-18, 005610-19	Critical Incident System

Licensee/Titulaire de permis

Park Lane Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Park Lane Terrace
295 Grand River Street North PARIS ON N3L 2N9

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

CYNTHIA DITOMASSO (528), EMMY HARTMANN (748), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, 29, 30, 31 and June 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 2019.

This Critical Incident Inspection included:
Log # 024694-18, # 025615-18, # 026242-18, # 027156-18, # 028483-18 related to resident to resident altercations,
Log # 005610-19 related to allegations of neglect of a resident.

This inspection was completed concurrently with Complaint Inspection #2019_695156_0002.

Non compliance related to LTCHA s. 6(1)(a) identified during this inspection was included in Complaint Inspection Report #2019_695156_0002 and issued as a Voluntary Plan of Correction (VPC).

Non compliance related to LTCHA s. 6(7) identified during this inspection was included in Complaint Inspection Report #2019_695156_0002 and issued as a Voluntary Plan of Correction (VPC).

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Associate Director of Clinical Services, Physiotherapist, Occupational Therapist, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

The inspectors also observed the provision of care and services, reviewed documents including but not limited to, clinical health records, meeting minutes, staffing schedules, complaint logs, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
0 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)

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

Critical Incident System (CIS) #2779-000014-19, log #005610-19, was submitted to the director, in March 2019, outlining allegations of neglect of a resident.

The home's policy titled Abuse-Prevention, Elimination & Reporting Policy, effective date: September 2018, stated that "it is mandatory that staff immediately report alleged, suspected or witnessed incident to the Registered Staff member on duty. The Registered Staff member must immediately contact the Executive Director, Director of Clinical Services or delegate. It is mandatory that the Executive Director/ Director of Clinical Services/ delegate notify the Ministry of Health and Long term Care via telephone and initiate a Critical Incident report (CI) via the ltchomes.net website".

During an interview with RPN #110, in May 2019, they indicated that they felt the resident was neglected, based on the home's policy, but they did not report the incident to management at the time in incident occurred.

During an interview with Director of Clinical Services (DCS), in May 2019, it was identified that this incident was reported late to the director, as management was not notified of the incident until three days after the incident.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risks of altercations and potentially harmful interactions between and among residents including identifying and implementing interventions.

Review of the plan of care for resident #003 identified that the resident was cognitively impaired. Review of the progress notes identified that the resident had responsive behaviours. The Minimum Data Set (MDS) Assessments from January and April 2018, identified that the resident's behaviour status had changed and in June 2018, a new intervention was implemented.

i. A progress note identified a trigger for the resident's behaviour and recommended new interventions with monitoring.
ii. Review of the progress notes for seven days following the recommendation identified that the resident continued to have responsive behaviours.

Interview with the DCS, who was not working in the home at the time of the incidents, confirmed that the recommendations were not communicated to the physician, and therefore, not implemented.

Interventions identified in an effort to manage the responsive behaviours were not implemented for resident #003. [s. 54. (b)]

Issued on this 16th day of July, 2019

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

Original report signed by the inspector.