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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 21, 2019	2019_549107_0014	017703-19, 020431-19	Complaint

Licensee/Titulaire de permis

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

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

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

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

MICHELLE WARRENER (107), LESLEY EDWARDS (506), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 30, October 1, 2, 3, 4, 8, 9, 10, 15, 16, 17, 18, 21, 22, 23, 24, 25, 2019

The following intakes were completed during this Complaint Inspection:
Log #017703-19 related to alleged staff to resident abuse/neglect and care concerns
Log #020431-19 related to plan of care and assessment of a resident

The following Critical Incident System intake related to the same issues (alleged abuse/neglect, care concerns) was completed during this Complaint inspection:
Log #017471-19, CIS#2779-000083-18

PLEASE NOTE: A written notification and Compliance Order related to s. 19(1), and O.Reg. 79/10, s. 71 (3)(a); A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6 (7), and s. 24(1)2; and a written notification related to LTCHA, 2007, c.8, s. 23(2) and O.Reg. 79/10, s. 40 were identified in this inspection and have been issued in Inspection Report 2019_549107_0013 (Log #: 012945-19, 014006-19, 014029-19, 014585-19, 015067-19, 016123-19, 016471-19, 016608-19, 017012-19, 017013-19, 017471-19, 017833-19, 018505-19, 018605-19, 018877-19), dated November 21, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with The Executive Director, Director of Clinical Services, Director of Culinary Services, Food Services Supervisor, Registered Dietitian, Director of Environmental Services, Employee Services Coordinator, Associate Directors of Clinical Services, registered nursing staff (Registered Nurses, Registered Practical Nurses), Personal Support Workers, Nursing Consultant, Physician, Dietary staff, Housekeeping staff, residents, and family of residents

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

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 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:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #033's plan of care was based on an interdisciplinary assessment of physical functioning and the type and level of assistance that was required related to activities of daily living, including hygiene.

During this inspection a concern was raised that the resident was no longer able to independently use a specific personal assistive services device (PASD), used to assist with hygiene, and it was impacting on their quality of life.

Resident #033 required the use of a PASD, which allowed the resident to be independent. During a discussion with PSW #142, they indicated that resident #033 was mostly able to be independent with hygiene.

A clinical note indicated that a concern was brought to the attention of staff related to the PASD. Non-nursing staff made a decision to replace the device with a different one.

A clinical note made by the Director of Clinical Services (DCS) #101, indicated resident #033, and another person, raised a concern related to the new PASD. They identified that the resident was now having difficulty independently using the device and this placed the resident at a greater risk for falling.

A clinical note made by the DCS, acknowledged that the current PASD placed the resident at increased risk for falling, and to mange this risk, they replaced the PASD with a different device. It was later identified that the new device did not work for the resident so another device was implemented.

During a discussion with resident #033, they confirmed the above noted issues with the PASD that had been provided and their concern that they could no longer complete independent care with hygiene. They verified that a non-nursing staff member and an equipment vendor, contracted by the home, brought a couple of PASDs for them to try and asked the resident to try them before they made a decision about which one would be implemented. Resident #033 verified that they had not been assessed by nursing staff or any other professional staff related to changing the PASDs.

During a discussion with the DCS, it was verified that a interdisciplinary assessment related to resident #033's functional abilities and requirements to perform independent activities related to hygiene had not been completed prior to changing the type of PASD on three occasions. [s. 26. (3) 7.]

Issued on this 2nd day of December, 2019

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

Original report signed by the inspector.