Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 3, 2020	2019_549107_0017	014230-19, 014231-19, 014232-19, 014233-19, 014234-19, 014235-19, 020138-19, 021333-19, 021642-19, 022611-19, 023378-19	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

MICHELLE WARRENER (107), JESSICA PALADINO (586), 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): Dec 11, 12, 13, 16, 17, 18, 19, 20, 30, 2019, January 3, 7, 8, 9, 10, 2020

The following intakes were completed during this Critical Incident System inspection:
Log #020138-19, CIS#2779-000094-19 related to improper transfer
Log #021333-19, CIS#2779-000102-19 related to resident to responsive behaviours
Log #021642-19, AH IL-71954-AH/CI #2779-000103-19 related to resident to resident responsive behaviours
Log #023378-19, CIS#2779-000113-19 related to resident to resident responsive behaviours
Log #022611-19, AH IL-72418-AH/CI #2779-000108-19 related to alleged staff to resident abuse

The following intakes were completed during a Follow Up Inspection, completed concurrently with this Critical Incident Inspection:
Log #014230-19 related to CO#001 from inspection #2019_695156_0002 / 027240-18, 027542-18, 028981-18, 032042-18, 032200-18, 000979-19, 001854-19, 001856-19, 001857-19, 001858-19, 001860-19, 001861-19, 002297-19, 002298-19, 002299-19, 003675-19, 009120-19 regarding s. 6. (5), CDD Oct 07, 2019
Log #014231-19 related to CO#002 from inspection #2019_695156_0002 / 027240-18, 027542-18, 028981-18, 032042-18, 032200-18, 000979-19, 001854-19, 001856-19, 001857-19, 001858-19, 001860-19, 001861-19, 002297-19, 002298-19, 002299-19, 003675-19, 009120-19 regarding s. 6. (10), CDD Oct 07, 2019
Log #014232-19 related to CO#003 from inspection #2019_695156_0002 / 027240-18, 027542-18, 028981-18, 032042-18, 032200-18, 000979-19, 001854-19, 001856-19, 001857-19, 001858-19, 001860-19, 001861-19, 002297-19, 002298-19, 002299-19, 003675-19, 009120-19 regarding s. 8. (3), CDD Oct 07, 2019
Log #014233-19 related to CO#004 from inspection #2019_695156_0002 / 027240-18, 027542-18, 028981-18, 032042-18, 032200-18, 000979-19, 001854-19, 001856-19, 001857-19, 001858-19, 001860-19, 001861-19, 002297-19, 002298-19, 002299-19, 003675-19, 009120-19 regarding s. 76. (2), CDD Oct 07, 2019
Log #014235-19 related to CO#005 from inspection #2019_695156_0002 / 027240-18, 027542-18, 028981-18, 032042-18, 032200-18, 000979-19, 001854-19, 001856-19, 001857-19, 001858-19, 001860-19, 001861-19, 002297-19, 002298-19, 002299-19, 003675-19, 009120-19 regarding r. 8. (1), CDD Oct 07, 2019
Log #014234-19 related to CO#006 from inspection #2019_695156_0002 / 027240-18, 027542-18, 028981-18, 032042-18, 032200-18, 000979-19, 001854-19, 001856-19, 001857-19, 001858-19, 001860-19, 001861-19, 002297-19, 002298-19, 002299-19, 003675-19, 009120-19 regarding r. 36., CDD Oct 07, 2019

PLEASE NOTE: A written notification and Compliance Order related to O.Reg. 79/10, s. 8 (1) (b), identified in concurrent inspection #2019_549107_0018 / 021814-19, 022441-19, 023440-19, was issued in this report.

During the course of the inspection, the inspector(s) spoke with residents, the Executive Director, Director of Clinical Services, Associate Directors of Clinical Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Co-ordinator, Behavioural Support Ontario (BSO) staff, Restorative Care staff, Director of Programs and Support Services, Food Services Supervisor, Registered Dietitian, Food Service Workers, Director of Business Services, Director of Environmental Services, Housekeepers, Laundry staff, Maintenance staff, contracted service providers

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **2 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2019_695156_0002	506
LTCHA, 2007 S.O. 2007, c.8 s. 6. (5)	CO #001	2019_695156_0002	586
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #004	2019_695156_0002	506
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #003	2019_695156_0002	506

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Critical Incident System (CIS) #2779-000094-19 was submitted to the Director outlining an incident where resident #014 was transferred using a mechanical lift with only one staff present.

The licensee's policy, "Mechanical Lifts", indicated that all lifts and transfers completed with a mechanical lift required the participation of a minimum of two staff members.

According to the home's internal investigation notes, Registered Practical Nurse (RPN) #126 saw resident #014 transferred using a mechanical lift with the supervision of only Personal Support Worker (PSW) #122.

In an interview with RPN #126 they confirmed that PSW #122 was the only PSW present at the time, and that the resident was transferred using the mechanical lift. The RPN indicated that the lift was only to be operated by two staff at a time, and that using one staff was unsafe for the resident and put them at risk of falling. The RPN also confirmed that the call bell was not activated by PSW #122 to request assistance with the transfer.

During interview with Inspector #586, PSW #122 confirmed that they independently transferred the resident using the mechanical lift and should have called for assistance beforehand, confirming it was an unsafe transfer.

In an interview with the Director of Clinical Services (DCS) #101, they confirmed that the resident should not have been moved without another staff member present. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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 :

The licensee failed to ensure that where the Act or this Regulation required the licensee of long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

1. Ontario Regulation 79/10 s. 48 (1) 1 and in reference to O. Reg s.49 (2), states "The licensee is required to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident required, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls."

Specifically, staff did not comply with the licensee's policy, 'Post Fall Algorithm 5.2' which was part of the licensee's 'Falls Prevention Policy' (section 5.1), and the 'Head Injury Routine Policy' (section 6.2). The algorithm stated that when a resident sustained a fall, staff were to complete a pain assessment at the time of the fall, along with a fall risk assessment, and physiotherapist referral. In addition, a head injury routine (HIR) would be completed for all resident falls that were not witnessed and for witnessed falls that included the possibility of a head injury.

While completing this follow-up inspection, it was noted that the licensee failed to comply with compliance order #005 from inspection #2019_695156_0002, served on July 15, 2019, with a compliance due date of October 7, 2019, specifically:

Ensure that, should residents #032, #038, #040 and #041, or any other resident, sustain a fall, they are assessed and provided care as appropriate according to the licensee's policies in their falls prevention and management program to reduce the incidence of falls and the risk of injury, specifically the policies:

a) Post Fall Algorithm 5.2 and
b) Head Injury Routine 6.2.

i. Resident #011, who was identified as resident #038 in the previous compliance order, was at risk for falls and sustained an unwitnessed fall on a specified date.

A review of the resident's clinical record identified that a HIR that was scheduled to be completed was not completed as required. Interview with Associate Director of Clinical Services (ADCS) #104 confirmed that the HIR was not documented as completed at the frequency required for resident #011's post fall.

ii. Resident #015 was at risk for falls and sustained an unwitnessed fall on a specified date. A review of resident #015's clinical record confirmed that a pain assessment, a fall risk assessment, and a physiotherapist referral were not completed. A HIR was not completed for seven out of nine times it was scheduled to be completed in the 24 hours. Interview with the Director of Clinical Services (DCS) #101 confirmed that the staff did not follow the licensee's policy for falls prevention by failing to complete the required post-fall assessments and they did not complete the HIR at the frequency required for resident #015's post-fall.

iii. Resident #016 was at risk for falls and was found in a position that would indicate the resident had fallen. It was confirmed by ADCS #104 that resident #016 attempted to self transfer. The incident was unwitnessed.

A review of the clinical record confirmed that there were no post-fall assessments completed, such as risk management, post fall assessment, pain assessment, physiotherapist referral or HIR, until the next morning. Interview with Registered Nurse (RN) #133 confirmed that at the time they did not feel it was a fall. RN #133 reviewed the licensee's policy for definition of a fall and they confirmed that the incident met the definition of a fall and they did not follow the home's policy for the their falls prevention and management program. The RN did not complete the required assessments which were to be completed at the time of the resident's fall.

iv. Resident #017 was at risk for falls and sustained an unwitnessed fall where they hit their head. A review of the resident's clinical record confirmed that six out of nine of the scheduled HIR's were not completed as required post fall. Interview with the DCS #101 confirmed that the staff did not follow the home's policy for falls prevention and failed to complete the required HIR at the frequency required for resident #015's post-fall. (506)

2. Ontario Regulation 79/10 s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Specifically, staff did not comply with the licensee's policy "Medication Administration' (policy number IIA01), which stated under 'Documentation' that the individual who administered the medication was to record the administration on the resident's electronic Medication Administration Record (eMAR) and that when an as needed (prn) medication was administered, the following documentation was provided on the eMAR:
- Date and time of administration, dose, route of the administration (if other than oral), and, if applicable, the injection site.
- Complaints or symptoms for which the medication was given.
- Results achieved from giving the does and the time results were noted.
- Documentation of person recording administration and documentation of person recording effects, if different from the person administering the medication.

While completing this follow-up inspection, it was noted that the licensee failed to comply with compliance order #005 from inspection #2019_695156_0002, served on July 15, 2019, with a compliance due date of October 7, 2019, specifically:
Ensure that, should resident #038 or any other resident, receive medication, that the administration of the medication is documented as appropriate according to the licensee's policies in the medication administration program, specifically the policy IIA01.

Resident #011, who was identified as resident #038 in the previous compliance order, was at risk for falls and sustained an unwitnessed fall on a specified date. Resident #011 was sent to the hospital.

The resident's progress notes identified that Registered Nurse (RN) #147 gave the resident a medication and then sent the resident to the hospital. A review of the eMAR did not include the medication that was given to the resident, and therefore, did not indicate the time of administration, dose, route and symptoms for which the medication was given.

An interview with RN #147 confirmed that they did not document on the eMAR that they gave the resident a medication. An interview with the DCS #101 confirmed that the policy for medication administration, specifically documentation, was not followed. (506)

3. In accordance with O. Reg. 79/10, s. 68 (2)(a) and in reference to Ontario Regulation 79/10, s. 73 (1) 6 the licensee was required to have policies and procedures relating to dietary services and required to ensure that food and fluids were being served at a temperature that was both safe and palatable to the residents.

A. Specifically, staff did not comply with the licensee's policies, "Food Temperature Control" and "Thermometer Use & Calibration". The policies directed dietary staff to take and record food temperatures at every meal prior to meal service using a probe thermometer to measure both hot and cold temperatures. The Food Temperature Control policy identified that foods were to be hot held at 60 degrees Celsius (140 degrees Fahrenheit) or hotter and directed staff to reheat food and notify the manager if foods were not within the required temperature range.

In an identified home area, the temperature monitoring record book included recorded temperatures that were below the minimum temperature range for hot foods for two specified dates. At one of the identified meals, the temperature of the hot entrée was recorded as 135 degrees Fahrenheit (F), minced entrée 138 degrees F, pureed entree was 135 degrees F. At another identified meal the minced meat was recorded at 131 degrees F, and at another meal the minced meat was recorded at 138 degrees F, pureed meat at 138 degrees F, minced vegetables at 136 degrees F, and pureed vegetables at 139 degrees F.

During interview with Inspector #107 Dietary Aide #155, who served the identified meals, confirmed that the temperatures recorded were less than the minimum temperature required in the home's policy and that action was not taken to increase the temperatures to the required range prior to service. The Dietary Aide also confirmed that the Food Services Supervisor #137 was not informed when the food temperatures were below the required temperature range.

B. Staff did not comply with the licensee's policy, "Thermometer Use & Calibration". The policy stated that food temperatures were to be recorded at every meal prior to meal service using a probe thermometer to measure both hot and cold temperatures. The policy also required staff to calibrate the thermometers on the first day of the month and to record the calibration on the Thermometer Calibration Record.

During interview with Inspector #107, Food Service Supervisor #137 (FSS) confirmed that food thermometers were not calibrated monthly, as per the licensee's policy. The

FSS confirmed that the thermometer in the identified home area was inaccurate and the likely cause of the low temperatures recorded for the two dates.

Also, at an identified meal in a specified home area, staff did not record food temperatures prior to service and temperature records were not available for review by Inspector #107 at the end of the meal service. Dietary Aide #151 confirmed the temperatures were not recorded in the book prior to meal service.(107) [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: 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.

On a specified date a medication cart was parked outside of and around the corner from a specified dining room. Staff were in the dining room and did not have a visible sight-line to the medication cart. Residents were in the hallway outside the dining room.

Inspector #107 observed an open medication pouch that contained a white pill sitting on-top of the locked medication cart. The medication pouch was labeled with resident #025's name.

Inspector #107 went to the dining room to notify staff and Registered Practical Nurse (RPN) #156 returned to the medication cart with the Inspector. Registered Practical Nurse #156 confirmed that medication was not to be left on-top of the medication cart when the cart was left unsupervised and that the medication had not been stored securely. [s. 129. (1) (a) (ii)]

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 with O. Reg. 79/10, 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,
(ii) that is secure and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

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.

Critical Incident System (CIS) report #2779-000103-19 was submitted to the Director outlining an incident between residents #004 and #005. As a result of the incident, a device was implemented for resident #004 to prevent future occurrences. The resident's written plan of care, which front line staff used to direct care, did not include the use of the device. This was confirmed by the Associate Director of Clinical Services (ADCS) #104. They acknowledged that resident #004's written plan of care did not include the use of the device. [s. 6. (1) (a)]

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

Resident #006 had an Responsive Behaviour Assessment completed over a six day period that reflected the resident had exhibited no behaviours.

Critical Incident System (CIS) report # 2779-000113-19 was submitted to the Director, and outlined an incident of responsive behaviours between resident #006 and resident #002 within that six day period.

The Responsive Behaviour Assessment did not capture this incident. In an interview with the ADCS #104 they confirmed the Responsive Behaviour Assessment did not include the incident and acknowledged that resident #006's assessment was not consistent with and did not compliment the incident assessment. [s. 6. (4) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

This is additional evidence to support non-compliance with existing compliance order not past-due from November 2019 Critical Incident Inspection 2019_549107_0013, CO #006, with a compliance due date of February 28, 2020.

On a specified date and home area both doors to the servery and both doors to the dining room were left unlocked, open, and unattended by staff. Inspector #107 was able to enter the servery area where there were several hazardous chemicals accessible under the sink (labeled as poisonous, causing skin and serious eye irritation, flammable, hazardous if consumed orally), hot steam wells (had not cooled fully from the meal), and a hot water dispenser that was not restricted.

Staff were not in the area when Inspector #107 arrived in the dining room and Inspector #107 notified a Recreation staff (#154) who confirmed that the area was unlocked and unsupervised. Recreation staff #154 then attempted to lock the doors to the servery, however, one of the doors was unable to be secured.

Recreation staff #154 confirmed that the servery was a non-residential area that was to be locked and secured when unattended by staff. The Recreation staff stated that if the door to the servery was unable to be locked and secured that the door to the dining room was to be secured to prevent unsupervised access by residents. A key was available to lock the dining room doors and was located just outside the dining room. [s. 9. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Please note: This evidence further supports compliance order (CO) #004, that was issued on November 21, 2019, related to the same section, of the O. Reg. 79/10, s. 131 (2), with a compliance due date of February 28, 2020. This non-compliance occurred prior to the compliance due date.

Resident #001's physician ordered the resident to receive a certain medication and the medication was to be administered every hour as needed.

Information on a Critical Incident System (CIS) report that was submitted to the Director, progress notes, and the electronic medication administration record (EMAR) was reviewed by Inspector #506.

Resident #001 requested to have their medication as ordered, every one hour as needed. Registered Practical Nurse (RPN) #125 did not provide the medication to the resident. Interview with the Director of Clinical Services (DCS) #101 confirmed the medication was not administered to resident #001 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 5th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107), JESSICA PALADINO (586), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2019_549107_0017
Log No. / No de registre :	014230-19, 014231-19, 014232-19, 014233-19, 014234-19, 014235-19, 020138-19, 021333-19, 021642-19, 022611-19, 023378-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 3, 2020
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 :	Sandy Hall

Ontario

Ministry of Long-Term Care

Ministère 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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_695156_0002, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of the Ontario Regulation 79/10.

Specifically, the licensee must:
1. Ensure resident #014, or any other resident requiring the use of a mechanical lift, are not transferred in a lift without the participation of at least two staff.

2. Ensure staff member #122 reviews, with a member of the management team, the licensee's "Mechanical Lifts" policy and are provided re-education on the expectations of the home.

3. Keep a documented record of the education provided to staff member #122.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #006 from inspection #2018_695156_0006 issued on July 15, 2019, with a compliance date of October 7, 2019. The licensee was ordered to do the following:

"The licensee must be compliant with O. Reg. 79/10, r. 36.
The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. The plan must include but is not limited to the following:
1. A description of how the home will ensure that staff use safe transferring and positioning devices or techniques when assisting resident #011 and all other residents.
2. The dates for retraining for safe transferring and positioning for PSW #121

and any other staff. A copy of the training records shall be maintained in the home.
3. A description of monitoring and prevention strategies including an auditing process to ensure that resident #011 and all other residents requiring the use of a mechanical lift are safely transferred, positioned and not left unattended. Include who will be responsible for implementing the strategies/plan."

The licensee completed steps 1-3 of the order, however, failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Critical Incident System (CIS) #2779-000094-19 was submitted to the Director outlining an incident where resident #014 was transferred using a mechanical lift with only one staff present.

The licensee's policy, "Mechanical Lifts", indicated that all lifts and transfers completed with a mechanical lift required the participation of a minimum of two staff members.

According to the home's internal investigation notes, Registered Practical Nurse (RPN) #126 saw resident #014 transferred using a mechanical lift with the supervision of only Personal Support Worker (PSW) #122.

In an interview with RPN #126 they confirmed that PSW #122 was the only PSW present at the time, and that the resident was transferred using the mechanical lift. The RPN indicated that the lift was only to be operated by two staff at a time, and that using one staff was unsafe for the resident and put them at risk of falling. The RPN also confirmed that the call bell was not activated by PSW #122 to request assistance with the transfer.

During interview with Inspector #586, PSW #122 confirmed that they independently transferred the resident using the mechanical lift and should have called for assistance beforehand, confirming it was an unsafe transfer.

In an interview with the Director of Clinical Services (DCS) #101, they confirmed

that the resident should not have been moved without another staff member present. [s. 36.]

The severity of this issue was determined to be a level 2 as there was minimum risk to the resident. The scope of the issue was a level 1 as it was isolated. The home had a level 5 compliance history as there was on-going noncompliance with this subsection of the Act that included:
Compliance Order (CO) issued May 27, 2016 (2016_343585_0007) with a compliance due date of July 16, 2016 and complied on August 26, 2016;
CO issued May 25, 2017 (2017_556168_0006) with a compliance due date of June 30, 2017 and complied on December 28, 2017;
CO issued January 15, 2019 (2018_695156_0006) with an amended compliance due date of May 1, 2019; and,
CO issued July 15, 2019 (2019_695156_0002) with a compliance due date of October 17, 2019. (586)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2020

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_695156_0002, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of Ontario Regulation 79/10.

Specifically, the licensee must:

1. Ensure that residents #011, #015, #016, and #017, or any other resident who sustains a fall, are assessed and provided care as appropriate according to the licensee's policies in their falls prevention and management program to reduce the incident of falls and the risk of injury, specifically the policies:
a) Post Fall Algorithm 5.2, and
b) Head Injury Routine 6.2.

2. Provide education to registered staff #133 on the definition of a fall and what is considered a fall. All records of the training are to be maintained.

3. Continue with the previously ordered January 24, 2019 (2018_556168_0011) and July 15, 2019 (2019_695156_0002) auditing process to ensure that all residents who sustain a fall are assessed as required based on the falls policies. Document any follow up/corrective action taken when appropriate. The audits shall be completed at times and frequencies determined by the licensee and made available to the Inspector(s) at the time of the follow-up inspection.

4. Ensure that when resident #011 or any other resident, receives medication, that the administration of the medication is documented, as appropriate, according to the licensee's policies in their medication administration program, specifically, the policy IIA01.

5. Ensure that all food temperatures are taken and recorded prior to meal service, that corrective action is taken if recorded food temperatures are outside the required temperature range and that all food thermometers are routinely calibrated, as outlined in the home's policies "Food Temperature Control" and "Thermometer Use & Calibration".

Grounds / Motifs :

1. The licensee failed to comply with the following compliance order CO #005 from inspection #2019_695156_0002, issued on July 15, 2019, with a compliance date of October 7, 2019.

The licensee was ordered to be compliant with s. 8 (1) (b) of Ontario Regulation 79/10.

Specifically, the license was ordered to:

1. Ensure that, should residents #032, #038, #040 and #041, or any other resident, sustain a fall, they are assessed and provided care as appropriate according to the licensee's policies in their falls prevention and management program to reduce the incidence of falls and the risk of injury, specifically the policies:
a) Post Fall Algorithm 5.2 and
b) Head Injury Routine 6.2 revised May 2019

2. Continue with the previously ordered January 24, 2019 (2018_556168_0011) auditing process to ensure that all resident who sustain a fall are assessed as required based on the falls policies. Document any follow up action taken when appropriate. The audits shall be completed at times and frequencies determined by the licensee and made available to the Inspector(s) at the time of the follow-up inspection.

3. Ensure that, should resident #038 or any other resident, receive medication, that the administration of the medication is documented as appropriate according to the licensee's policies in their medication administration program, specifically the policy IIA01.

The licensee completed step 2 in CO #005 but did not complete steps 1 and 3. The licensee failed to comply with s. 8 (1) (b).

The licensee failed to ensure that where the Act or this Regulation required the licensee of long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

1. Ontario Regulation 79/10 s. 48 (1) 1 and in reference to O. Reg s.49 (2), states "The licensee is required to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident required, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls."

Specifically, staff did not comply with the licensee's policy, 'Post Fall Algorithm 5.2' which was part of the licensee's 'Falls Prevention Policy' (section 5.1), and the 'Head Injury Routine Policy' (section 6.2). The algorithm stated that when a resident sustained a fall, staff were to complete a pain assessment at the time of the fall, along with a fall risk assessment, and physiotherapist referral. In addition, a head injury routine (HIR) would be completed for all resident falls that were not witnessed and for witnessed falls that included the possibility of a head injury.

While completing this follow-up inspection, it was noted that the licensee failed to comply with compliance order #005 from inspection #2019_695156_0002, served on July 15, 2019, with a compliance due date of October 7, 2019, specifically:

Ensure that, should residents #032, #038, #040 and #041, or any other resident, sustain a fall, they are assessed and provided care as appropriate according to the licensee's policies in their falls prevention and management program to reduce the incidence of falls and the risk of injury, specifically the policies:
a) Post Fall Algorithm 5.2 and
b) Head Injury Routine 6.2.

i. Resident #011, who was identified as resident #038 in the previous compliance order, was at risk for falls and sustained an unwitnessed fall on a specified date.

A review of the resident's clinical record identified that a HIR that was scheduled to be completed was not completed as required. Interview with Associate Director of Clinical Services (ADCS) #104 confirmed that the HIR was not documented as completed at the frequency required for resident #011's post fall.

ii. Resident #015 was at risk for falls and sustained an unwitnessed fall on a specified date. A review of resident #015's clinical record confirmed that a pain assessment, a fall risk assessment, and a physiotherapist referral were not completed. A HIR was not completed for seven out of nine times it was scheduled to be completed in the 24 hours. Interview with the Director of Clinical Services (DCS) #101 confirmed that the staff did not follow the licensee's policy

for falls prevention by failing to complete the required post-fall assessments and they did not complete the HIR at the frequency required for resident #015's post-fall.

iii. Resident #016 was at risk for falls and was found in a position that would indicate the resident had fallen. It was confirmed by ADCS #104 that resident #016 attempted to self transfer. The incident was unwitnessed.

A review of the clinical record confirmed that there were no post-fall assessments completed, such as risk management, post fall assessment, pain assessment, physiotherapist referral or HIR, until the next morning. Interview with Registered Nurse (RN) #133 confirmed that at the time they did not feel it was a fall. RN #133 reviewed the licensee's policy for definition of a fall and they confirmed that the incident met the definition of a fall and they did not follow the home's policy for the their falls prevention and management program. The RN did not complete the required assessments which were to be completed at the time of the resident's fall.

iv. Resident #017 was at risk for falls and sustained an unwitnessed fall where they hit their head. A review of the resident's clinical record confirmed that six out of nine of the scheduled HIR's were not completed as required post fall. Interview with the DCS #101 confirmed that the staff did not follow the home's policy for falls prevention and failed to complete the required HIR at the frequency required for resident #015's post-fall. (506)

2. Ontario Regulation 79/10 s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Specifically, staff did not comply with the licensee's policy "Medication Administration' (policy number IIA01), which stated under 'Documentation' that the individual who administered the medication was to record the administration on the resident's electronic Medication Administration Record (eMAR) and that when an as needed (prn) medication was administered, the following documentation was provided on the eMAR:
- Date and time of administration, dose, route of the administration (if other than

oral), and, if applicable, the injection site.
- Complaints or symptoms for which the medication was given.
- Results achieved from giving the does and the time results were noted.
- Documentation of person recording administration and documentation of person recording effects, if different from the person administering the medication.

While completing this follow-up inspection, it was noted that the licensee failed to comply with compliance order #005 from inspection #2019_695156_0002, served on July 15, 2019, with a compliance due date of October 7, 2019, specifically:
Ensure that, should resident #038 or any other resident, receive medication, that the administration of the medication is documented as appropriate according to the licensee's policies in the medication administration program, specifically the policy IIA01.

Resident #011, who was identified as resident #038 in the previous compliance order, was at risk for falls and sustained an unwitnessed fall on a specified date. Resident #011 was sent to the hospital.

The resident's progress notes identified that Registered Nurse (RN) #147 gave the resident a medication and then sent the resident to the hospital. A review of the eMAR did not include the medication that was given to the resident, and therefore, did not indicate the time of administration, dose, route and symptoms for which the medication was given.

An interview with RN #147 confirmed that they did not document on the eMAR that they gave the resident a medication. An interview with the DCS #101 confirmed that the policy for medication administration, specifically documentation, was not followed. (506)

3. In accordance with O. Reg. 79/10, s. 68 (2)(a) and in reference to Ontario Regulation 79/10, s. 73 (1) 6 the licensee was required to have policies and procedures relating to dietary services and required to ensure that food and fluids were being served at a temperature that was both safe and palatable to the residents.

A. Specifically, staff did not comply with the licensee's policies, "Food Temperature Control" and "Thermometer Use & Calibration". The policies directed dietary staff to take and record food temperatures at every meal prior to meal service using a probe thermometer to measure both hot and cold temperatures. The Food Temperature Control policy identified that foods were to be hot held at 60 degrees Celsius (140 degrees Fahrenheit) or hotter and directed staff to reheat food and notify the manager if foods were not within the required temperature range.

In an identified home area, the temperature monitoring record book included recorded temperatures that were below the minimum temperature range for hot foods for two specified dates. At one of the identified meals, the temperature of the hot entrée was recorded as 135 degrees Fahrenheit (F), minced entrée 138 degrees F, pureed entree was 135 degrees F. At another identified meal the minced meat was recorded at 131 degrees F, and at another meal the minced meat was recorded at 138 degrees F, pureed meat at 138 degrees F, minced vegetables at 136 degrees F, and pureed vegetables at 139 degrees F.

During interview with Inspector #107 Dietary Aide #155, who served the identified meals, confirmed that the temperatures recorded were less than the minimum temperature required in the home's policy and that action was not taken to increase the temperatures to the required range prior to service. The Dietary Aide also confirmed that the Food Services Supervisor #137 was not informed when the food temperatures were below the required temperature range.

B. Staff did not comply with the licensee's policy, "Thermometer Use & Calibration". The policy stated that food temperatures were to be recorded at every meal prior to meal service using a probe thermometer to measure both hot and cold temperatures. The policy also required staff to calibrate the thermometers on the first day of the month and to record the calibration on the Thermometer Calibration Record.

During interview with Inspector #107, Food Service Supervisor #137 (FSS) confirmed that food thermometers were not calibrated monthly, as per the licensee's policy. The FSS confirmed that the thermometer in the identified home area was inaccurate and the likely cause of the low temperatures

recorded for the two dates.

Also, at an identified meal in a specified home area, staff did not record food temperatures prior to service and temperature records were not available for review by Inspector #107 at the end of the meal service. Dietary Aide #151 confirmed the temperatures were not recorded in the book prior to meal service. (107) [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as there was minimal risk or harm to the residents. The scope of the issue was a level 3 as it related to more than 67% of the residents reviewed. The home had a level 5 history of on-going non-compliance with this section of the Act that included:

Voluntary Plan of Correction (V)C) issued May 27, 2016, (2016-343585-0007) (156);
Written Notification (WN) issued September 7, 2016, (2016-210169-0012);
Written Notification (WN) issued September 7, 2016, (2016-210169-0011);
Voluntary Plan of Correction (VPC) issued February 13, 2018, (2017-689596-0013);
Voluntary Plan of Correction (VPC) issued January 15, 2019, (2018-695156-0006);
Compliance Order (CO) issued January 24, 2019 (2018_556168_0011) with a compliance due date of April 29, 2019; and
Compliance Order (CO) issued July 15, 2019 (2019_695156_0002) with a compliance due date of October 7, 2019.
(506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2020

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 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 3rd day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER

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