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
Jul 29, 2020	2020_555506_0018	022901-19, 022902-19, 022903-19, 022904-19, 022905-19, 022906-19, 022907-19, 001501-20, 002213-20, 002214-20, 003024-20	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

LESLEY EDWARDS (506), JESSICA PALADINO (586)

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): July 15, 16, 17, 20, 21, 22, 23 and 24, 2020.

The following Critical Incidents System (CIS) Inspections were conducted:
001501-20- related to falls prevention; and,
003024-20- related to responsive behaviours.

The following Follow-up Inspections were conducted concurrently with this inspection:
002903-19- related to nutrition and hydration;
002904-19- related to nutrition and hydration;
002901-19- related to medication administration;
022902-19- related to safe and secure home;
022905-19- related to safe and secure home;
022906-19- related to prevention of abuse and neglect;
022907-19- related to safe and secure home;
002213-20- related to personal support services; and,
002214-20- related to falls prevention, medication administration and dining services.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOCs), Director of Environmental Services (DES), Registered Nurses, Registered Practical Nurses, Director of Culinary Services (DCS), Behavioural Supports Ontario (BSO), Personal Support Workers, dietary aides, housekeeping staff and residents.

During the course of the inspection the inspectors conducted tours of the home, observed resident care, meal service and medication administration, reviewed clinical records, policies and procedures, internal compliance plans, training records and conducted interviews.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 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. (2)	CO #004	2019_549107_0013	506
O.Reg 79/10 s. 16.	CO #007	2019_549107_0013	506
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #005	2019_549107_0013	586

O.Reg 79/10 s. 36.	CO #001	2019_549107_0017	506
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2019_549107_0013	586
O.Reg 79/10 s. 71. (3)	CO #002	2019_549107_0013	586
O.Reg 79/10 s. 73. (2)	CO #003	2019_549107_0013	586
O.Reg 79/10 s. 8. (1)	CO #002	2019_549107_0017	506
O.Reg 79/10 s. 9. (1)	CO #006	2019_549107_0013	586

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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, its furnishings, and equipment, were kept clean and sanitary.

The dining room for the Sunrise and Twin home areas were not clean. A tour of the home was conducted on an identified date in July 2020, around 1020 hours and 1145 hours. In both dining rooms, the walls around the dining rooms, table legs, window sills, and window cranks had dried food splashes on them. The radiators lining the back walls had large pieces of old food debris. The baseboards lining the dining room had large amounts of dust and crumbs. The back doors of the Sunrise dining room as well as the Grand dining room had large cob webs and visible dirt. The home was toured again on an identified date in July 2020 and the above was still observed. During interviews with Dietary Aide #121 and Housekeeper #124, they stated that those areas of the dining room were to be cleaned on a weekly basis, as part of a deep clean.
The Director of Environmental Services confirmed that the dining rooms were not kept clean and sanitary. [s. 15. (2) (a)]

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 home, its furnishings, and equipment, were kept clean and sanitary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On November 21, 2019, the following compliance order (CO #004) from inspection # 2019_549107_0013, was made under O. Reg. 79/10, s. 131 (2) was issued:

The compliance due date was February 28, 2020.

The licensee complied with O. Reg. 79/10, s.131 (2); however failed to complete steps #1 and #2.

The licensee shall prepare, submit, and implement a plan to ensure that resident #009, resident #004 and any other resident, is administered medications as specified by the prescriber.
The plan must include, but is not limited to, the following:

1. The development and implementation of a resident identification system that reliably allows for residents to be identified by all staff administering medications.
2. The development and implementation of an education/training program for all registered staff who administer medications in the home, including registered staff who work in the home pursuant to a contract between the licensee and an employment agency, related to safe medication administration practices. Documentation of the completion of this training is to be maintained by the home for presentation to an Inspector.

The licensee failed to complete steps #1 and #2.

i. A review of the plan submitted by the licensee to the Hamilton Service Area Office (HSAO) on an identified date in December 2019, outlined the following identification system:

a. The home would be purchasing identification bracelets for all current residents, in addition to all new admissions, who upon arrival would be given the identification bracelet for the purpose of allowing residents to be reliably identified by staff for safe medication administration.
It was further communicated that there would be extra bracelets in the home if any bracelets were to be torn or damaged.
b. During an observation on an identified date in July 2020, the Long-Term Care Homes (LTCH) Inspector observed multiple residents without identification bracelets on.
c. An audit was completed on an identified date in July 2020 by the home, confirming that only four out of 118 residents were wearing identification bracelets.
d. An interview with the DOC on an identified date in July 2020, confirmed that they did introduce identification bracelets in February 2020 and a one-call was placed to all families to inform them of the new process and requested consent. The DOC confirmed that there were a significant number of residents or their substitute-decision makers (SDMs) that did not consent to the use of identification bracelets at the time of implementation.
e. A review of all current residents in the home confirmed that 64 percent of residents did not have any documentation in their clinical record to support that they refused the bracelet or that it was removed or damaged.
f. The DOC confirmed that staff were to let them know if a resident’s identification bracelet needed replacing; however, this was not being done.

The identification system was developed and implemented in February; however, there was no formal process in place to ensure this continued to be implemented. Furthermore, there was no identification system developed for resident's or SDM's who refused the arm band.

ii. A review of the education and training program documentation as required in step #2 of the CO identified that staff #123 did not complete their training until an identified date in March 2020, after the compliance due date of February 28, 2020. This was confirmed with the DOC on an identified date in July 2020.

The licensee has failed to comply with every order made under this Act. [s. 101. (3)]

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 the licensee complied with the following requirement of the LTCHA and comply with every order made under this act, to be implemented voluntarily.

WN #3: 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).

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.

A CIS #2799-000004-20 was submitted to the Director on an identified date in January 2020, regarding resident #002.

A review of resident #002's clinical record confirmed that resident #002 was a fall risk. An observation of resident #002 on an identified date in July 2020, identified that resident #002 had interventions put in place to mitigate their fall risk. An interview with PSW #108 on an identified date in July 2020, confirmed that the resident was to have the identified fall intervention. A review of the resident's written plan of care, which front line staff use to direct care, did not include the identified intervention. Interview with the ADOC #102 on an identified date in July 2020, confirmed that the plan of care did not set out the planned care for resident #002 as it did not include the use of the specified intervention. [s. 6. (1) (a)]

Issued on this 29th day of July, 2020

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

Original report signed by the inspector.