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
Oct 27, 2021	2021_868561_0010	003325-21, 015087-21, 015990-21	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

DARIA TRZOS (561), FARAH_ KHAN (695)

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 23, 24, 27, 28, 29, 2021 and October 1, 4, 5, 6, 7, 8, 12, 13, 14, 2021.

The following intakes were inspected during this inspection:
log #003325-21 - related to multiple care areas,
log #015087-21 - related to Covid-19 surveillance and the Directive,
log #015990-21 - related to multiple care areas.

A Critical Incident (CI) inspection was conducted concurrently with this inspection with the inspection number 2021_868561_0009.

Inspector number 720920 was also present during this inspection

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Clinical Services (DOCS), Director of Culinary Services, Associate Director of Clinical Services (ADOCS), Advanced Practice Consultant (College of Nurses of Ontario), Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), personal support workers (PSWs), residents and family members.

During the course of the inspection, the inspector(s) observed provision of care, reviewed clinical records, investigation notes, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Skin and Wound Care
Sufficient Staffing

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)

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A resident’s written plan of care indicated that the resident had a condition and needed to be monitored for symptoms related to this condition. The registered staff were to monitor and record the resident's vital signs. On an identified date, the resident was feeling unwell and was assessed by registered staff. The resident’s vital signs were elevated, and the registered staff provided treatment. Registered staff indicated that they had reassessed the resident’s vital signs later that day and the resident’s condition improved. Clinical records were reviewed and did not have the vital signs documented. Registered staff stated that they had forgotten to document the reassessed vital signs in resident’s records.

Sources: resident’s plan of care; home’s policy Measuring Vitals Signs (revised January 1, 2020); interviews with staff. [s. 6. (9) 1.]

WN #2: 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 has failed to ensure that staff documented assessment of a resident when they were readmitted to the home from hospital, specifically vital signs monitoring.

A resident returned from the hospital on an identified date in 2021. Part of the readmission process in the home was to monitor and record resident's vital signs on each shift for a period of 72 hours. Clinical records were reviewed and identified that the resident's vital signs were not recorded for 72 hours. The DOCS confirmed that the process was to monitor vital signs for three days upon admission and readmission from hospital.

Sources: resident's progress notes, vital signs section in PCC and their chart; home's policy Measuring Vitals Signs; interviews with staff. [s. 30. (2)]

Issued on this 29th day of October, 2021

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

Original report signed by the inspector.