Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137
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Original Public Report

Report Issue Date: November 14, 2022	
Inspection Number: 2022-1270-0001	
Inspection Type: Complaint Follow up	
Licensee: Park Lane Terrace Limited	
Long Term Care Home and City: Park Lane Terrace, Paris	
Lead Inspector Nishy Francis (740873)	**Inspector Digital Signature**
Additional Inspector(s) Angela Finlay (705243)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 19 - 21, 24 – 28, 31, and November 1, 2022.

The following intake(s) were inspected:

- Intake# 00001383 (complaint) related to Staffing, Maintenance, Skin and Wound Care, Medication Management, Falls Prevention, and Bowel and Continence Care
- Intake# 00001434 (Follow-up) related to Prevention of Abuse
- Intake# 00003396 (Complaint) related to Prevention of Abuse

Previously Issued Compliance Order(s)

CO#001 for inspection #2021_868561_0009 has been complied with.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services

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Housekeeping, Laundry and Maintenance Services
Falls Prevention and Management
Continence Care
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister
NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive COVID-19 response measures for long-term care homes, the Licensee was required to ensure that enhanced environmental cleaning and disinfection for frequently touched surfaces was performed.

Rationale and Summary:
The home was declared to be in an outbreak.

The document from Public Health Ontario titled, "Key Elements of Environmental Cleaning in Healthcare Settings" last updated July 16, 2021, identified that frequently touched surfaces were to be cleaned and disinfected more than once daily during outbreak.

On identified dates, specific resident rooms were not cleaned or disinfected more than once daily during an outbreak. Housekeeping staff confirmed the rooms were not cleaned more than once a day during outbreak.

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When enhanced cleaning in outbreak areas did not occur, the management of outbreak areas and safety to residents was jeopardized.

Sources: Record review of Housekeeping Daily Room Checklist; High Touch Point Cleaning Checklist; Home's Pandemic Plan; Housekeeping Staff Routines; Key Elements of Environmental Cleaning in Healthcare Settings; Minister's Directive: COVID-19 response measures for long-term care homes; interviews with staff.
[740873]

WRITTEN NOTIFICATION: Plan of Care
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
On an identified date, a resident's family member indicated a finding related to continence care to the registered staff on shift.

Record review of resident's progress notes indicated a registered staff was notified of the finding. The registered staff documented they completed an intervention and continued to monitor the resident.

Record review of the resident's care plan indicated to notify the physician as needed for findings related to continence care. The physician was not notified about the finding.

Interview with registered staff confirmed when a finding is observed related to continence care, the physician is to be notified as specified in the resident's care plan.

When the care set out in the written plan of care is not provided to the resident as specified in the plan, there is a potential risk for the resident to be harmed and not receive care according to their assessed needs.

Sources: Resident clinical records; and interviews with staff.
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WRITTEN NOTIFICATION: Reports re: Critical Incidents
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (1) 1.

The licensee has failed to ensure that the Director was immediately informed of an emergency including an unplanned evacuation.

Rationale and Summary
On an identified date, staff reported smelling gas which led to 911 being called. The fire department was on scene and one resident unit was partially evacuated. No critical incident was reported to the Director.

Sources: Interview with the Executive Director; and document titled, "Fire/Evacuation Education Training Record".

[705243]

WRITTEN NOTIFICATION: Required Programs
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 48 (1) 3.

The licensee has failed to ensure that the continence care and bowel management program for a resident was implemented.

Rationale and Summary
The home’s Continence and Bowel Management policy stated that registered staff would implement individualized bowel routines as per the home’s approved Medical Directives.

A resident received medical treatment and required medication if they did not have a bowel movement as per the home’s Medical Directives.

On identified dates post medical treatment, the resident did not receive available bowel routine medications when they did not have a bowel movement.

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Not implementing the continence care and bowel management program by providing available bowel routine medications when indicated may have put the resident at risk of discomfort and incurring further bowel related issues.

Sources: The home's Continence and Bowel Management Program Policy Reference No.: 008010.00; resident clinical records; and interviews with staff.

[705243]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed when an outbreak of a disease of public health significance was declared in the home.

Rationale and Summary
The Director was not immediately informed when an outbreak of a disease of public health significance was declared in the home.

Sources: Interview with the Executive Director; Critical Incident Report.

[740873]

WRITTEN NOTIFICATION: Required Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg 79/10, s. 48 (1) (1) and O.Reg. 246/22, s. 53 (1) 1.

The licensee has failed to fully implement the required falls prevention and management program when staff failed to comply with this program for two residents.

Rationale and Summary
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the

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requirement was under s. 48 (1) (1) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 53 (1) (1) of O. Reg. 246/22 under the FLTCA.

In accordance with O. Reg. 246/22, s. 11 (1)(b) the licensee was required to ensure that the falls prevention and management program, had in place strategies to monitor residents, and that the strategy was complied with.

1) The home's Fall Prevention policy stated that registered staff would document details of a resident fall with or without injury in a specified location in the resident record. It also stated that registered staff would document in the progress notes a summary of the post fall investigation which included; the date and time of the fall, whether the fall was witnessed or unwitnessed, whether an injury was sustained from the fall, if it was a repeat fall, the probable root cause of the fall, what the medication review determined, what assessments were completed, whether the care plan had been reviewed and updated, and that the multidisciplinary team had met to determine root cause and develop interventions to reduce the risk of future falls or injuries.

A) A resident had falls on identified dates. Details of the resident fall in a specific location in the resident record and progress notes with a summary of the post fall investigation were not completed.

B) Another resident had falls on identified dates. None of these falls had a progress note with a summary of the post fall investigation.

The required documentation post fall that were present for both residents did not routinely identify the time the fall occurred, if it was a repeat fall, the probable root cause of the fall, what the medication review determined, what assessments were completed, whether the care plan had been reviewed and updated and that the multidisciplinary team had met to determine the root cause and develop interventions.

2) The home's Fall's Prevention policy specific to post fall management stated that if a resident had a fall that registered staff would complete a Fall Risk Assessment and Pain Assessment.

A) A resident had falls on identified dates. No Fall Risk Assessment or Pain

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Assessment were completed for either fall.

3) The home's Fall's Prevention policy specific to head injuries stated that a specified electronic assessment would be initiated for all resident falls that were not witnessed and for witnessed falls that included the possibility of a head injury. If the resident were to have the specified electronic assessment completed, the registered staff were to observe and chart in an additional electronic assessment and the frequency of HIR observations were as follows; every one hour for four hours and then every four hours for 24 hours for a total of ten checks.

A) A resident had a fall on an identified date. No specific electronic assessments were completed for this fall.

B) Another resident had several falls on identified dates. A specific electronic assessment was not completed as required on identified dates. An additional electronic assessment was also not completed as required on identified dates.

The home not fully implementing their falls management program made it difficult to determine the specifics of each fall and may have placed the residents at risk of having injuries go unnoticed and/or impaired the home's ability to reduce the incidents of future falls and/or injuries.

Sources: Resident's clinical records; the home's Fall Prevention Policy; and interviews with staff.

[705243]