Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: February 7, 2023	
Inspection Number: 2023-1270-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Park Lane Terrace Limited	
Long Term Care Home and City: Park Lane Terrace, Paris	
Lead Inspector Lisa Vink (168)	**Inspector Digital Signature**

INSPECTION SUMMARY

The Inspection occurred on the following dates: January 24, 25, 26, 27 and 31, 2023 and February 1, 2, and 3, 2023.

The following intakes were inspected:

- Intake: #00008208 for a Critical Incident (CI) Report - related to falls prevention and management and transferring and positioning techniques;
- Intake: #00011282 for a CI Report - related to plan of care;
- Intake: #00018965 for a CI Report - related to duty to protect and skin and wound care; and
- Intake: #00019050 for a complaint related to duty to protect, skin and wound care and plan of care.

The following intakes were completed in this inspection: intake 00001257; intake: 00011282; and intake 00002665, all which were related to falls prevention and management.

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

Falls Prevention and Management
Infection Prevention and Control
Skin and Wound Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (a)

The licensee failed to ensure that the written plan of care for a resident, set out the planned care for the resident.

Rational and Summary
A resident used a mobility device.
The device was set to allow independence and the use of additional equipment would impact the resident's ability to be independent.
A review of the plan of care, that was in place prior to an incident, identified the resident was independent with the device and required staff assistance for longer distances. There was no direction related to the use of additional equipment on the device when the resident received the assistance of staff.
The home's policy Assisting Residents Who Require Assistive Mobility Devices identified that all residents were to use additional equipment when they used a device with staff assistance unless otherwise noted in the plan of care.
The plan of care was revised following an incident related to the use of the additional equipment.

Sources: Review of clinical health record of a resident and policy Assisting Residents Who Require Assistive Mobility Devices and interviews with staff.

Date Remedy Implemented: September 28, 2022

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that a resident's substitute decision-makers (SDM) were given an

opportunity to participate fully in the development and implementation of the resident's plan of care.

Rational and Summary
A resident was unable to make decisions and had appointed SDMs.
The resident had areas of altered skin integrity, which were reported to the SDM.
On two occasions there were changes in the area(s) of altered skin integrity; however, the SDM was not immediately notified.
The SDM was not notified of the changes in the area(s) of altered skin integrity until a number of days later, to give them an opportunity to participate fully in the development and implementation of the plan of care.
Failure to provide the SDM the opportunity to participate fully in the development and implementation of the resident's plan of care resulted in the SDM being unaware of the changes in the resident's status and care needs.

Sources: Review of clinical records and assessments for a resident, and interviews with the SDM and staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rational and Summary

i. A resident presented with areas of altered skin integrity.
The Registered Dietitian (RD) was informed of the areas and completed an assessment which directed staff to submit another referral to the RD if skin condition worsened.
One of the areas deteriorated.
The RD was not initially informed of the worsening of the area.
Failure to refer the resident to the RD, when the area deteriorated, as set out in the plan of care had the potential to delay the implementation of additional nutritional interventions to support healing.

ii. A resident had an area of altered skin integrity.
The electronic Treatment Administration Record (eTAR) identified the specific treatment to be completed.
Progress notes identified an occasion where a staff member used a different treatment on the area.

Failure to provide care as set out in the plan of care related to the treatment of the area had the potential for staff to be unaware of care needs or actual interventions in place.

Sources: Review of clinical record for a resident including RD notes, progress notes, skin and wound assessments and eTARs and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)

The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Rational and Summary
A resident had an area of altered skin integrity.
The SDM was notified of the plan to have the physician reassess the area for the effectiveness of the treatment.
Staff included an entry in the physician's communication book for the area to be assessed.
The following day, the SDM observed the area and directed staff to transport the resident to the hospital as the area had not been assessed by the physician.
The resident was treated at the hospital and orders were received.
The staff and SDM were not aware that the physician had assessed the area as there the physician's notes were not available in the home nor documentation to identify the resident was seen/assessed.
A review of the physician's notes, available in the home at the time of the inspection, included documentation of an assessment of the area, their findings, and directions if the area did not improve.
Staff confirmed that notes of the physician's assessments were not available in the home and staff did not have immediate access to records or knowledge that the resident was assessed.
Failure to ensure that there was convenient and immediate access to the contents of the plan of care, specifically the physician's notes resulted in staff not being aware of assessments completed and the plan as identified by the physician.

Sources: Record review for a resident, review of physician's communication book, and interviews with the resident's SDM and staff. (168)

WRITTEN NOTIFICATION: General Requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that any actions taken with respect to a resident under the required skin and wound care program, including assessments and reassessments were documented.

Rational and Summary
i. A resident presented with areas of altered skin integrity.
There was no assessment completed to identify when one of the areas had resolved.

ii. A resident had areas of altered skin integrity which were being reassessed.
Documentation of reassessments were consistently completed; however, did not always include the measurements of the area(s) or their location(s).

Sources: A review of skin and wound assessments and progress notes for a resident and interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee failed to ensure that a resident, at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

Rational and Summary
A resident had altered skin integrity and was transported to the hospital.
They returned from the hospital, the following day; however, no head to toe /skin assessment was conducted by a member of the registered nursing staff, as required.

Sources: Review of the clinical record of a resident and interview with the staff.