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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 9, 2024
Inspection Number: 2024-1270-0003
Inspection Type: Critical Incident
Licensee: Park Lane Terrace Limited
Long Term Care Home and City: Park Lane Terrace, Paris

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 2-3, 2024

The following intake(s) were inspected:

- Intake #00122644, regarding alleged improper treatment of a resident.
- Intake #00126179, related to an outbreak

The following intake(s) were also completed:

- Intake #00128046, related to an outbreak

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
Two personal support workers were transferring a resident when the resident fell and sustained injuries.

The Director of Care stated during an interview that the staff completing the resident transfer improperly used equipment, causing the resident fall with injuries.

The resident fell due to unsafe transfer technique used by staff, resulting in injuries.

Sources: Residents clinical record and staff interviews.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief

Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The Licensee did not comply with the Ministry of Health's Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024. These recommendations require that Alcohol-based hand rubs (ABHR) must not be expired.

Rationale and Summary:
During an inspection, two expired ABHR dispensers were found throughout the home in areas accessible to residents, staff and visitors.

The infection control and prevention (IPAC) lead confirmed that the expired ABHR should have been replaced.

Using expired ABHR poses a potential risk of transmitting micro-organisms to residents, staff, and visitors.

Sources: Observations and staff interviews.