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

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Original Public Report

Report Issue Date: November 6, 2024	
Inspection Number: 2024-1270-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Park Lane Terrace Limited	
Long Term Care Home and City: Park Lane Terrace, Paris	
Lead Inspector Brandy MacEachern (000752)	**Inspector Digital Signature**
Additional Inspector(s) Melanie Northey (563)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 17, 18, 22, 23, 24, 25, 28, 29, 30, 31, 2024 and November 1, 4, 2024
The inspection occurred offsite on the following date(s): October 21, 2024
The following intake(s) were inspected:

- Intake: #00128754 - Proactive Compliance Inspection - 2024

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement

Palliative Care
Pain Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Council

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 63 (3)

Powers of Residents' Council

s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that when residents' council and food committee had advised the licensee of concerns or recommendations under paragraph 6 of subsection (1), the licensee, within 10 days of receiving the advice, responded to the Residents' Council in writing.

Rationale and Summary

During a Proactive Compliance Inspection, residents' council meeting minutes, informed the council had a concern related to the operation of the home.

In interview with the Administrator they advised that residents affected by this concern were followed up with verbally the day after the meeting, however a written response had not been provided to the council.

Additionally, during a record review of food committee meeting minutes from the previous three months, these minutes included concerns and recommendations raised by the residents at the committee meetings. In interview with the Director of Culinary Services, they advised that they followed up verbally with the residents' council president, but they did not provide a response in writing to the committee.

In interview, a resident on the council advised that the council did receive responses to their concerns and recommendations, but that this was done verbally and sometimes occurred at the following monthly meeting.

Sources: Residents' council meeting minutes, food committee meeting minutes, resident and staff interviews

WRITTEN NOTIFICATION: Family Council

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee has failed to ensure that when there was no family council, on an

ongoing basis they advised residents' families and persons of importance to residents of the right to establish a Family Council; and convened semi-annual meetings to advise such persons of the right to establish a Family Council.

Rationale and Summary
During a Proactive Compliance Inspection, it was identified the long-term care home did not have an active family council, and there were quarterly family forum meetings held for residents' families and persons of importance to residents to attend.

During a record review of the quarterly family forum meeting minutes from the previous year, there was no documentation identified that demonstrated the licensee had advised residents' families and persons of importance to residents of the right to establish a Family Council.

During interviews with the Administrator and the Director of Program and Support Services, they could not confirm that residents' families and persons of importance to residents had been informed of the right to establish a Family Council. They advised that this was something they should include in the family forum meeting agenda.

Sources: Family forum meeting minutes, staff and family interviews.

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain.

The licensee failed to ensure that the policies and protocols developed for the home's pain management program to identify pain were implemented in accordance with all applicable requirements under the act.

Ontario Regulation 246/22, s. 34 (1) (1) states, every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under each of the interdisciplinary programs required under section 53 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Ontario Regulation 246/22, s. 11 (1) (a) states, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Rationale and Summary
The Pain Assessment Program policy was in place and documented each resident would be monitored for presence of pain at identified intervals using designated assessment tools.

The Director of Care (DOC) stated the numeric rating scale and Pain Assessment in Advanced Dementia (PAINAD) were the clinically appropriate assessment instrument used to assess pain. The DOC stated the home used the Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines (BPG) to determine

that the numeric and PAINAD scales were validated tools.

RNAO Clinical Best Practice Guidelines for the Assessment and Management of Pain Third Edition dated December 2013, documented the numeric rating scale and the PAINAD were validated pain assessment tools and to refer to the "Assessment and Management of Pain clinical best practice guideline for further details on the indicators/components and considerations for each tool". The numeric and PAINAD assessed one aspect of pain such as intensity and nurses were to perform "a comprehensive pain assessment on persons screened having the presence, or risk of, any type of pain using a systematic approach and appropriate validated tools."

The DOC stated the registered nursing staff determined the effectiveness of a pain medication intervention by documenting the pain on a scale "1-10" or the PAINAD and would follow up to determine effectiveness by asking the resident or observing signs of pain relief. If the pain management intervention was ineffective in relieving pain, the DOC verified there was no formal process to complete a comprehensive pain assessment and there was no direction as part of the policy for registered nursing staff to complete a pain assessment when interventions were ineffective.

The DOC stated the policy does not provide clear direction when to complete the different types of pain assessments available for completion and when those pain assessments were to be completed.

The plan of care related to pain management was to be based on an assessment of the resident, and the assessment needed to be completed by the registered nursing staff when the resident's pain was not relieved by initial interventions. Residents were at risk of not being assessed using a clinically appropriate assessment to determine individualized clinical indicators of pain to build or revise the plan of care to manage pain and implement effective interventions.

Sources: Pain Assessment Program policy, RNAO BPG, resident clinical record, and staff interviews.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident who was exhibiting an area of altered skin integrity was reassessed at least weekly by an authorized person.

Rationale and Summary
During a Proactive Compliance Inspection, a resident was identified by the long-term care home who was exhibiting areas of altered skin integrity.

During a record review in PointClickCare (PCC) under the skin and wound tab for the resident, an aera of altered skin integrity was noted to have a photo uploaded with a documented assessment. This was not completed again until twelve days later.

In interview with the Associate Director of Clinical Services, they acknowledged that an assessment was missed, which they explained they had identified this through audits they conducted, and at the time of identifying the missed assessment had requested the staff to complete one.

The missed weekly wound assessment may have put the resident at risk for a delay in interventions to promote healing and prevent infection.

Sources: Resident health records, staff interviews.

WRITTEN NOTIFICATION: Pain Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Rationale and Summary
The Director of Care (DOC) stated the numeric rating scale and PAINAD were the clinically appropriate assessment instrument used to assess pain. The DOC stated the home used the Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines (BPG) to determine that the numeric and PAINAD scales were validated tools.

RNAO Clinical Best Practice Guidelines for the Assessment and Management of Pain Third Edition dated December 2013, documented the numeric rating scale and the PAINAD were validated pain assessment tools and to refer to the "Assessment and Management of Pain clinical best practice guideline for further details on the

indicators/components and considerations for each tool". The numeric and PAINAD assessed one aspect of pain such as intensity and nurses were to perform "a comprehensive pain assessment on persons screened having the presence, or risk of, any type of pain using a systematic approach and appropriate validated tools."

The DOC stated every resident in the home had a Pain Assessment or Pain Assessment in Advanced Dementia (PAINAD) completed on admission, with a significant change in condition, and quarterly under the assessment tab in Point Click Care (PCC). The DOC stated the the nurse would look for trends before completing a pain assessment, that the completion of a full pain assessment when initial interventions were ineffective was not practical, and identified the pain assessment policy did not provide that legislative requirement.

A resident had an order for the administration of a pain medication. The Point of Care (POC) documentation completed by Personal Support Workers (PSWs) identified a trend that pain was occurring at a specific time of day for the resident.

The most recent Pain Assessment was completed with no documentation completed related to the rate when the pain was at its least, what made the pain better, what was the rate when the pain was at its worst, what made the pain worse, if the pain was continuous or intermittent, the cause of the pain, level and quality of the pain, or the effects of pain on activities of daily living and quality of life.

The Director of Care stated there was a trend in the ineffectiveness of the pain medications administered.

The registered nursing staff did not ensure that when the resident's pain was not relieved by the pain medications and the resident experienced pain on multiple days, the resident was assessed using a clinically appropriate assessment. The DOC

stated the Pain Assessment or PAINAD were the full comprehensive assessments designed to assess pain. The resident continued to have unresolved pain without an assessment and the plan of care remained unchanged.

Sources: resident clinical record review, resident and staff interviews.

WRITTEN NOTIFICATION: Administration of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident had an order for the administration of a pain medication. The Point of Care (POC) documentation completed by Personal Support Workers (PSWs) identified a trend that pain was occurring at a specific time of day for the resident. There were orders for an as needed medication for pain with no administration during this time.

The Director of Care verified the resident was not administered the medications as needed to relieve unresolved pain in accordance with the directions for use specified by the prescriber.

The registered nursing staff did not ensure that when the resident's pain was not

relieved by the scheduled pain medications and the resident experienced pain on multiple days, the resident was administered pain medications as needed when routinely scheduled pain medications were ineffective.

Sources: resident clinical record review, resident and staff interviews.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the Continuous Quality Improvement Initiative report was provided to the Residents' Council.

Rationale and Summary
During a Proactive Compliance Inspection, the Quality Improvement Lead was not able to confirm that a copy of the Continuous Quality Improvement Initiative report was provided to the Residents' Council.

In interview with a resident who was a member of the residents' council, they did not recall the report being shared. In interview with the Administrator, they advised they the information contained in the report had been shared with residents' council but could not confirm that a copy of the report was provided.

Sources: Resident and staff interviews