Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 18, 2013	2013_188168_0017	H-000093-13	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

LISA VINK (168)

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): April 16 and 17, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Food Service Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), Dietary Aides, residents and a family member.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed relevant documents and toured the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Personal Support Services

Snack Observation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. Not all equipment was kept clean and sanitary.

Mugs set on tables in a specified dining room on April 16, 2013, for the supper meal service, were inspected at approximately 1650 hours. A number of mugs (six of eight inspected) were noted not to be clean and had evidence of debris on the inside of the mugs. During this meal service it was also observed that three plastic lip plates, stored on the steam table, ready for use, had signs of wear and dried on food residue. China plates stored in stacks on the steam table, ready for use, were noted to have debris on them and a number were observed to be moist with some pooling of water on the top surface, from the dish washer. The condition of the dishes was confirmed by the dietary aide. During a tour of the dish room on April 17, 2013, mugs were inspected while still on the dish rack after being washed by the dish washer. Most of the mugs inspected were observed to have some debris on the inside of the mug. The condition of the mugs was confirmed by the dietary aide. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all equipment is kept clean and sanitary, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Not all staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #001 was assessed for bowel/bladder functioning on February 4, 2013. This assessment noted that the bowel management program included incontinent products and toileting . The bladder management program also included a scheduled toileting plan. The Resident Assessment Protocol (RAP) completed for the same time period, identified that the resident was routinely toileted. The plan of care identified that the resident was no longer toileted and used products for containment. PSW and Registered Staff on the day shift indicated that the resident was not routinely toileted, only when specific triggers had occurred for bowel functioning. PSW staff interviewed on the evening shift identified that the resident was toileted on April 16, 2013, prior to supper and that this was the usual practise, however toileting was not always effective. The plan of care was not consistent with the assessments completed in February 2013, nor was the routine of staff interviewed. [s. 6. (4)]

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Issued on this 18th day of April, 2013

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

original signed by inspector
Apr 18. 2013.