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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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 25, 2014	2014_267528_0017	H-000413-14	Resident Quality Inspection

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

CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582), KELLY HAYES (583), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 14, 15, 16, 17, 22, 23 and 24, 2014

This inspection report includes findings of non-compliance for complaint log #'s H-000244-24 and H-000311-14, which were done concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Education Coordinator, Programs Director, Food Services Manager (FSM), Registered Dietitian (RD), Nursing Unit Managers (NUM), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Dietary Aides, Registered Nurses (RN), Personal Support Workers (PSW), and Environment Services Manager (ESM).

During the course of the inspection, the inspector(s) toured the home and observed the provision of care and services, reviewed relevant clinical health records, policies and procedures, staffing schedules, and complaints logs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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. The licensee did not ensure that all furnishings and equipment in the home were

kept clean and sanitary.

A. In April 2014, while observing the noon meal service in the Sunrise Court dining room it was observed that not all dishes, specifically, bowls, plastic raised plates and mugs were clean and sanitary. The dishes, prior to use were noted to have dried on food particles and a rough texture on some areas, which was confirmed with the dietary aide, serving the meal. In April 2014, clean dishes were observed in the Heritage Court dining room, prior to the noon meal service. Soiled plates and mugs with dried on food particles and a rough texture on some areas was noted. Interview with the FSM confirmed that the dishes were not clean and it was identified that staff were not consistently rinsing dirty dishes before placing them in the dishwasher and/or cleaning the washer daily as directly. The staff removed the soiled dishes and washed the dishes before use.

B. Areas of the home and were not kept clean, specifically:
i. The tub lifts in the Heritage South, Sunrise Court and Twin River home areas were noted to be soiled on the underside after cleaning was completed by staff, in April 2014.
ii. Showers in Sunrise Court, Heritage South and Twin River were noted to be soiled, with debris in the drains and not ready for immediate use when observed in April 2014. Staff reported that residents prefer bathing in the tub and as a result the showers were not used. Interview with the ESM in April 2014, confirmed that the areas were not kept clean and provided information about cleaning routines and procedures in the home. [s. 15. (2) (a)]

2. The licensee did not ensure that the home was maintained in a good state of repair.

Several areas of the home were noted to in disrepair, specifically:
i. The floor in the Cobblestone Cafe, near the library, was identified to have a large crack expanding almost two thirds across the width of the floor.
ii. The resident washroom, across from the Twin River dining room, was noted to have areas of wall damage caused by the legs of a mechanical lift, an area of the flooring peeled away from the wall and a non operational toilet paper holder.
iii. In April 2014, it was observed that tiles in the Heritage South spa area were missing off the wall and the shower head was noted to have a constant leak, which could not be turned off by housekeeping staff on request.
iv. The shower head on Twin River was noted to have a constant leak.
v. The flooring in Sunrise Court tub room had a seam which was no longer sealed

and missing flooring near the drain.
Tour with the ESM in April 2014, confirmed a number of the identified areas in need of repair as well as identified plans which the home had in place to address the areas of concern identified . [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #18 was observed to use and had a physician's order for a lap belt when up in the wheelchair. The use of the belt was not included in the document that the staff refer to as the "care plan". This omission of planned care for the resident was confirmed during an interview with the registered nursing staff. [s. 6. (1) (a)]

2. The licensee did not ensure that 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.

A. Resident #10 had a history of demonstrating responsive behaviours. The coding completed for the Minimum Data Set (MDS) quarterly assessment in January 2014, for mood and behaviour patterns identified that the resident's mood and behaviours deteriorated since the last review. A review of the Resident Assessment Protocols (RAP's) completed for the same time period noted that the resident had experienced no changes in mood or behaviour and that the plan of care remained current. Interview with the RAI Coordinator confirmed that the coding and RAP 's completed for January 2014 were not consistent and did not complement each other.

B. Resident #14 had a history of bladder and bowel incontinence. The coding completed for the MDS quarterly assessment in June 2013, indicated that the resident was incontinent of bowel all (or most) of the time. Review of bowel history from Point of Care (POC) in June 2013, revealed the resident was occasionally incontinent of stool. Interview with the RAI Coordinator confirmed that the MDS coding for bowel assessment from June 2013 was not consistent with the resident's care needs reflected in POC. (520) [s. 6. (4) (a)]

3. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A. Review of the plan of care for resident #15 indicated that medications were to be crushed in apple sauce. In April 2014, registered staff was observed to administer one whole tablet in apple sauce to the resident. Interview with registered staff confirmed that the tablet administered could have been crushed without altering the medication's actions and that the it was not crushed as specified in the plan.

B. The meal service report and restorative dining program list that the dietary aids referred to, located in resident #18's dining room specified that the resident required a lipped plate and two handled cups with lid. During lunch observation in April 2014, resident #18 did not receive the lipped plate or two handled cups with lid. The RD verified adaptive equipment was not used as specified in the plan of care. (583)

C. In April 2014, the noon meal service was observed in the Sunrise Court dining room. At the completion of the meal residents #41 and #42 were served and fed "super pudding" by the PSW. Interview with the dietary aide serving the meal and a

review of the therapeutic dessert list confirmed that the residents were not to receive the pudding and that was not included as part of their plans of care. (168) [s. 6. (7)]

4. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A. In April 2014, observed resident #14 with an indwelling urinary catheter. Review of the progress notes indicated that the physician ordered a catheter to be inserted in March 2014 to assist with wound healing. The plan of care indicated that the resident was incontinent of bladder and instructed staff to change adult brief as needed. Interview with registered staff confirmed that as of April 2014, the plan of care was not updated to include the indwelling catheter and appropriate catheter care nursing interventions.

B. In April 2014, resident #14 was noted to be on a special care mattress. Review of the progress notes revealed that the intervention was suggested by registered staff in December 2013, to prevent skin breakdown. Interview with registered staff confirmed that as of April 2014, the plan of care was not updated to include the special care mattress.

C. Resident #40 had a history of demonstrating responsive behaviours. A review of the clinical record and staff interviews confirmed that the types of behaviours demonstrated increased and the resident became increasingly challenging to manage in the fall of 2013, into early 2014, including physical aggression towards another resident, taking items with force and rummaging for specified items. The plan of care in place at the time that these behaviours were demonstrated was not revised to include the changes in the behaviours or interventions of staff, which was confirmed with nursing staff. (168)

D. Resident #48 had a history of responsive behaviours. A review of the clinical record and staff interviews confirmed that a new behavioural trigger for the resident was identified in January 2014, which was a change in need and required specific interventions. The plan of care in place at the time that this need was identified was not revised to include the change in the triggers or interventions required of staff. (168) [s. 6. (10) (b)]

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:
i. the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complements each other.
ii. the care set out in the plan of care is provided to the resident as specified in the plan.
iii. the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, the resident was assessed in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A. According to the plan of care and observation resident #18 used a hi-low bed with two half bed rails in the raised position when in bed. A review of the clinical record did not include an assessment of the resident related to the bed rails used. Interviewed the nursing staff identified that when the home purchased the hi-low beds, which included the half rails, the beds were distributed to residents based on need however a formalized assessment of the rails was not completed.

B. According to the plan of care and observation resident #10 used a hi-low bed with two half bed rails in the raised position when in bed. A review of the clinical record did not include an assessment of the resident related to the bed rails used. The nursing staff identified that when the home purchased the hi-low beds, which included the half rails, the beds were distributed to residents based on need however a formalized assessment of the rails was not completed.

C. According to the plan of care and observation resident #14 used two full bed rails raised when in bed to assist with bed mobility and safety. A review of the clinical record did not include an assessment of the resident related to the bed rails used. Interview with the DOC confirmed that a formalized assessment of the rails was not completed. (528) [s. 15. (1) (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 where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee did not ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Subsection 33(4)4 of the Long Term Care Homes Act, identified that the use of a personal assistance services device (PASD) may be included in the plan of care only if it was consented to by the resident or a substitute decision maker of the resident with the authority to give the consent. Resident #18 was identified in the plan of care and during observation to use two bed rails in the raised position when in bed and a tilt wheelchair for safety and positioning. A review of the clinical record did not include consent for the use of the PASD's. Interview with nursing staff identified that the home did not obtain consents for the use of PASD's. [s. 33. (3)]

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 a PASD described in subsection (1) is used to assist a resident with a routine of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The plan of care for resident #14 indicated that the resident had multiple areas of new altered skin integrity. Review of the progress notes revealed that the resident's was not assessed by registered staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment for the following:

i. In September 2013, direct care staff notified registered nursing staff of a new open area. No assessment using a clinically appropriate assessment instrument was completed.
ii. In September 2013, a second area of altered skin integrity was documented by registered staff and a dressing was applied. No assessment using a clinically appropriate assessment instrument was completed.
iii. In November 2013, registered staff noted reddened open areas to legs and dressings were applied. No assessment using a clinically appropriate assessment instrument was completed.

Interview with the Education Coordinator confirmed that initial skin and wound

assessments were not completed by registered staff, using a clinically appropriate assessment tool for resident #014. [s. 50. (2) (b) (i)]

2. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The plan of care for resident #14 indicated that the resident had multiple areas of new altered skin integrity. Review of the health care record revealed that the resident was not reassessed by registered staff for the following areas of skin breakdown:

i. In September 2013, direct care staff notified registered nursing staff of a new open area. No weekly assessments were completed until December 2013, at which time, registered staff documented the wound was open and excoriated, and a dressing was applied. Interview with direct care staff confirmed the area was now closed.
ii. In September 2013, an new open area was documented by registered staff and a dressing was applied. No weekly wound assessment was noted until October 2013, at which time registered staff documented the wound to be healed.
iii. In October 2013, registered staff noted a new wound and treatment was applied. Weekly wound assessments were not completed until November 2013, at which time, the wound was documented to be open. No further mention of the wound was noted in the progress notes. Interview with registered staff confirmed that the wound was currently healed.

Interview with the Education Coordinator confirmed that weekly skin and wound assessments were not completed by registered staff for resident #14 as outlined above. [s. 50. (2) (b) (iv)]

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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; and is reassessed at least weekly by a member of the registered staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the actions taken to meet the needs of the resident with responsive behaviours included documentation of interventions and the resident's responses to the interventions.

A. According to the clinical record and staff interview resident #18 demonstrated a number of responsive behaviours including the resistance of care and self injury. The behavioural symptoms Resident Assessment Protocol (RAP) completed for the assessment of March 10, 2014, included a note that "staff report many episodes of resistive care although POC charting does not reflect this". Progress notes reviewed for the time period of December 2013, until April 2014, included a number of examples where the resident demonstrated behaviours, however did not consistently include the interventions of staff. Interview with registered staff confirmed that staff did consistently respond to the resident's demonstrated behaviours and were able to identify effective strategies as recorded in the plan of care. It was also confirmed that all interventions as a result of responsive behaviours would be recorded in the progress notes.

B. According to the clinical record and staff interview resident #40 demonstrated a number of responsive behaviours including the resistance of care, wandering, and physical aggression towards staff and others. Progress notes reviewed for the time period of November 2013, until April 2014, included a number of examples where the resident demonstrated behaviours, however the notes did not consistently include the interventions of staff. Interview with registered staff confirmed that staff did consistently respond to the resident's demonstrated behaviours and were able to identify effective strategies as recorded in the plan of care to manage the behaviours. Staff interviewed confirmed that all staff interventions and resident behaviours would be recorded in the progress notes. [s. 53. (4) (c)]

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 the actions taken to meet the needs of the resident with responsive behaviours including assessments, reassessments and interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that all residents with a change of 5 per cent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and that outcomes were evaluated.

Resident #11's weight decreased 5.7 percent from December 2013 to January 2014 showing a significant change. Review of the plan of care did not include a nutrition assessment by the Registered Dietitian (RD) in the month of January 2014 in reference to this weight loss. Interview with the RD confirmed that the resident was not on a planned weight loss program and was not assessed for significant weight loss in January 2014. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with a change of 5 percent body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the infection prevention and control program.

A. The home had a Hand Hygiene Program Policy, effective date January 2013. This program indicated that hand hygiene was to be completed before initial and after resident and /or resident environmental contact. In April 2014, while observing the noon meal service it was identified that staff did not consistently complete hand hygiene before and after resident or resident environmental contact. Staff were observed to be removing dirty dishes from the dining room tables and then serving meals to residents or assisting with feeding activities without consistently completing hand hygiene between the tasks.

B. The home had a Routine Practices procedure effective January 2013, and a Resident Identification procedure effective October 2013, which indicated that "personal care supplies (lotions, creams, soaps, razors) should not be shared between residents" and that "belongings such as personal care items are labeled if the resident shares a room". In April 2014, a number of unlabeled personal care supplies were identified in spa areas as identified below:
i. In the Sunrise Court tub room the following unlabeled items were found in the cupboard: a used deodorant and open and used jars of zinc, Noxema and aloe cream.
ii. In the Twin River shower room a used hairbrush and nail clippers.
iii. In the Twin River tub room the following unlabeled items were found in the cupboard: five used deodorants, three used brushes and four combs, and a jar of each petroleum jelly and zinc cream.
iv. In the Grand River tub room three used and unlabeled hairbrushes were found.
v. In the Heritage Court South spa room unlabeled jars of zinc cream, petroleum jelly and Vitarub and three unlabeled and used hairbrushes. [s. 229. (4)]

2. The licensee did not ensure that all residents were offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Residents #43, #44, and #45 were admitted to the home in 2013. A review of the clinical records for the residents identified that they did not receive immunization against tetanus and diphtheria in accordance with the schedules posted on the Ministry website. Resident #45 had a signed consent for tetanus and diphtheria however there was no documentation that the immunization had been completed, which was confirmed with the registered staff. Interview with the Infection Control lead confirmed that the home did not consistently offer residents immunization for tetanus and diphtheria prior to 2014. [s. 229. (10) 3.]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident were kept locked.

In April 2014, the emergency exit door on Heritage South was identified to be unlocked and unattended. The door lead to an unsecured outside area when opened and was equipped with a key pad, which was lit red when observed. Management staff were informed of the door and confirmed that it should be locked at all times. Maintenance staff were called immediately and it was noted that the door was locked when checked fourty minutes later. [s. 9. (1) 1. i.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

Review of the Residents' Council meeting minutes from April 2013 to present did not include any documentation to indicate that the meal and snack times were reviewed at the meetings. Interviews with both the Residents' Council President and Programs Director confirmed that the meal and snack times were not reviewed by the Residents' Council. [s. 73. (1) 2.]

2. The licensee did not ensure that foods were served at a temperature that was both safe and palatable.

In April 2014, resident #50 stated that food was sometimes not warm enough. In April 2014, temperatures were checked at lunch in the Twin River dining room and the meatballs were recorded to be 47 degrees Celsius and the egg salad sandwich was recorded to be 7.7 degrees Celsius. The homes "Food Service Temperature & Use of Thermometers Policy, Section 3.2, effective July 2013" referenced the temperature criteria from the Food Safety Code of Practice 2011, which specified holding temperatures of hot food to be greater than 60 degrees Celsius and holding temperature for cold food to be less than 4 degrees Celsius. Interview with the RD confirmed that the temperatures of the meatballs and egg salad sandwich were not within the homes temperature requirements. [s. 73. (1) 6.]

Issued on this 2nd day of June, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582), KELLY HAYES (583), LISA VINK (168)
Inspection No. / No de l'inspection :	2014_267528_0017
Log No. / Registre no:	H-000413-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 25, 2014
Licensee / Titulaire de permis :	PARK LANE TERRACE LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	PARK LANE TERRACE 295 GRAND RIVER STREET NORTH, PARIS, ON, N3L-2N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOE ANNE HOLLOWAY

To PARK LANE TERRACE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall ensure that all dishes and shower rooms are kept clean and sanitary.

Grounds / Motifs :

1. The licensee did not ensure that all furnishings and equipment in the home were kept clean and sanitary.

A. On April 14, 2014, while observing the noon meal service in the Sunrise Court dining room it was observed that not all dishes, specifically, bowls, plastic raised plates and mugs were clean and sanitary. The dishes, prior to use were noted to have dried on food particles and a rough texture on some areas, which was confirmed with the dietary aide, serving the meal. On April 17, 2014, clean dishes were observed in the Heritage Court dining room, prior to the noon meal service. Soiled plates and mugs with dried on food particles and a rough texture on some areas was noted. Interview with the FSM confirmed that the dishes were not clean and it was identified that staff were not consistently rinsing dirty dishes before placing them in the dishwasher and/or cleaning the washer daily as directly. The staff removed the soiled dishes and washed the dishes before use.

B. Areas of the home were not kept clean, specifically the showers in Sunrise Court, Heritage South and Twin River were noted to be soiled, with debris in the drains and not ready for immediate use when observed on April 14, 2014. Staff reported that residents prefer bathing in the tub and as a result the showers were not used. Interview with the ESM on April 24, 2014, confirmed that the areas were not kept clean and provided information about cleaning routines and procedures in the home. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of April, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

Service Area Office /
Bureau régional de services : Hamilton Service Area Office