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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 7, 2016	2016_210169_0011	024554-16 AND 017007-16	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

YVONNE WALTON (169)

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): August 16, 17, 18, 25, 2016

During the course of the inspection, the inspector observed care areas during the day and evening shift, observed meal service at lunch and dinner, reviewed clinical records, policies and procedures and reviewed minutes of meetings/training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Restorative Co-ordinator, Physiotherapy Aide, Registered Nursing Staff, Personal Support Workers, Housekeeping staff, Dietary Staff, Residents and Families

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures for the application of a wheelchair accessory was complied with. In March, 2016 a skin alteration was observed on resident #001 due to the improper application of the accessory.
The Restorative Co-ordinator was interviewed and confirmed all staff are provided training on the removal and replacement of the accessory, during initial orientation and employment. The Restorative Co-ordinator was unable to provide any documentation to verify the training, however confirmed a wheelchair is taken to the training and all staff are shown how to remove and replace accessories.
Resident #001 sustained an injury due to improper placement of the accessory. The staff did not follow the procedure implemented in the home, relating to wheelchair accessory application. [s. 8. (1) (a),s. 8. (1) (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 that ensures 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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the home was kept clean. Throughout the entire home during the four day observation, the carpets throughout the entire home were observed to be heavily soiled with buckling of the carpets in some areas. The housekeeping staff were interviewed and identified the carpets are steam cleaned regularly, however due to the environmental humidity, the stains return within one day. This was confirmed by the Manager of housekeeping and the Administrator. The home has initiated a plan to replace carpets on one home area, however the staining was observed throughout the entire home. [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 that ensures that, (a) the home, furnishings and equpment are kept clean and sanitary, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking. In August, on two separate days, during the noon meal, staff were observed feeding up to four residents at the same time.
One home area, four residents were sitting at the same table and one staff member was observed assisting all four residents. Three of the four residents required total assistance and one required intermittent feeding assistance. The written plans of care for all four residents directed staff to provide total assistance for feeding assistance. Staff confirmed the four residents required total feeding assistance.
Another home area, two residents were sitting at a table and another resident was sitting at a different table. The staff member was observed assisting two residents, then going to the other table to assist the third resident. This occurred several times during the meal service. The written plans of care for all three resident directed staff to provide total assistance for feeding assistance. Staff confirmed the three residents required total feeding assistance.
Another home area, two tables were observed with four residents at each table and one staff member. The staff member was observed providing total assistance to three residents. The staff members confirmed they were assisting three residents who required total assistance. [s. 73. (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 that ensures that, (a) no person simultaneously assists more than two residents who need total assistance with eating or drinking, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen. On August 17, 2016 an audit was completed of sixteen rooms in one home area. The audit was completed to determine how many windows had functioning screens on the windows. It was determined that six out of sixteen windows did not have screens in place. The maintenance log book was reviewed and it was noted there was documentation of a missing screen in a lounge, however this was not repaired. The daily nursing report identified a racoon was trying to enter the home area through the window as there wasn't a screen in place to prevent entry. Interview with the maintenance staff and manager confirmed the lack of screens on the windows in the home area. It was noted screens were ordered six weeks prior to this inspection, however there were no screens in the home to replace as needed over the summer months, resulting in residents not being able to open their windows when desired.
This was confirmed by the nursing staff, family interviews and the maintenance staff. [s. 16.]

Issued on this 7th day of September, 2016

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

Original report signed by the inspector.