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
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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
May 24, 2017	2017_555506_0009	013139-16, 018611-16, 024957-16, 033046-16, 001646-17	Critical Incident System

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

LESLEY EDWARDS (506), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 22, 23, 24, 27, 28, March 1, 2, 3, 7 and 8, 2017.

This Critical Incident Inspection was completed concurrently with Complaint inspection numbers 2017_556168 _0006/log #032841-16, 004249-17,004516-17. Non compliance for s. 6 (7) and s. 6 (10) b, r. 36. and r. 49. (2) will be identified on inspection report 2017_556168 _0006/log #032841-16, 004249-17,004516-17.

This Critical Incident inspection was conducted related to plan of care, complaints process, skin and wound management, maintenance service, fall prevention strategies, safe and secure home, responsive behaviours and duty to protect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), former Executive Director and DOC, Environmental Service Manager (ESM), Maintenance staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), Behavioural Supports Ontario resource nurse (BSO), former employee who worked in the position as a Social Service Worker and residents.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed clinical records, policies and procedures, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **1 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. 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 :

The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

A. Resident #053 was sent to the hospital following an incident, where they sustained an injury on an identified date in November 2016. A review of the clinical record identified that the resident returned from the hospital with an area of altered skin integrity that was sustained during the incident prior to hospitalization, which had been covered with a dressing. A review of the clinical record did not include a head to toe assessment of the

resident on return from the hospital. The DOC acknowledged that the resident did not receive a skin assessment upon their return from hospital.
This finding of non compliance was identified during Critical Incident Inspection 2779-000028-16. (Inspector #506)

B. Resident #021 was admitted to the hospital following an incident, where they sustained an injury in 2016. A review of the clinical record identified that at the time that the resident returned, to the home, from hospital they had new areas of altered skin integrity, which were covered with dressings. Interview with RPN #101 verified that they did not complete a skin assessment of the resident on their return from hospital and only changed the dressings and referred the areas to the wound nurse for assessment.
A review of the clinical record did not include a head to toe skin assessment of the resident on return from the hospital, only referred the areas to the wound nurse for assessment. A review of the clinical record did not include a head to toe assessment of the resident on return from the hospital as confirmed by nursing management staff #107. The resident did not receive a skin assessment upon their return from hospital.
This finding of non compliance was identified during Critical Incident Inspection 2779-000019-16.
(Inspector #168) [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a 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 is specifically designed for skin and wound assessment.

A. Resident #053 was sent to the hospital on an identified date in November 2016, where they sustained an injury causing an area of altered skin integrity which was covered with a dressing. A review of the clinical record identified that they did not document an assessment of the new area of altered skin integrity, using a clinically appropriate assessment instrument. The DOC acknowledged that the home did not complete a skin assessment using a clinically appropriate assessment in point click care.
This finding of non compliance was identified during Critical Incident Inspection 2779-000028-16.

B. Resident #021 was admitted to the hospital on an identified date in August 2016, where they sustained an injury. A review of the clinical record identified that at the time that the resident returned from the hospital they had new areas of altered skin integrity, which were covered with dressings. Interview with RPN #101 verified that they did not

document an assessment of the new areas of altered skin integrity, using a clinically appropriate assessment instrument. The RPN verified that they did not fully assess the areas and only commented on the areas in the progress notes and referred the areas to the wound care nurse for assessment.
A review of the clinical record did not include an assessment of the areas of altered skin integrity using a clinically appropriate assessment tool as verified by nursing management staff #107. (Inspector #168)
This finding of non compliance was identified during Critical Incident Inspection 2779-000019-16. [s. 50. (2) (b) (i)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 residents that have altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital and when a resident has altered skin integrity an assessment is completed using a clinically appropriate assessment that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #2: 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 failed to ensure that for residents demonstrating responsive behaviours that the behavioural triggers are identified and strategies are developed and implemented to respond to these behaviours.

i. A review of resident #053's clinical record confirmed that the resident displayed responsive behaviours The home had referred the resident to BSO to help manage the resident's responsive behaviours. A review of the BSO notes from an identified date in December 2016, indicated that the home should implement a strategy to avoid responsive behaviours. An interview with the DOC on an identified date in March 2017, acknowledged that the home did not trial this strategy. The clinical record confirmed that responsive behaviours were continuing. The BSO again made the recommendation on an identified date in January 2017, to implement the strategy. A review of the clinical record indicated that this was attempted once and was successful. The home then went into an outbreak and the trial had to be ended and was not trialled again once the outbreak was completed. The most recent progress note on an identified date in February 2017, indicated that the resident was displaying responsive behaviours because the identified strategy was not in place. The DOC acknowledged that strategies were not implemented to assist with managing the resident's responsive behaviours.
ii. Resident #053 had several incidents of documented responsive behaviours. These behaviours were documented on the progress notes and in the Point of Care (POC) documentation. These responsive behaviours were not included in the document that the home refers to as the care plan, nor were any triggers identified, any goals or interventions developed to respond to these responsive behaviours. The DOC acknowledged that these responsive behaviours were not included in the resident's plan

of care to respond to the resident's responsive behaviours.
This finding of non compliance was identified during Critical Incident Inspection 2779-000028-16. [s. 53. (4) (b)]

2. The licensee failed to ensure that residents demonstrating responsive behaviours 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.

Resident #053 was experiencing responsive behaviours. The resident was sent to the hospital for assessment and the resident returned with an area of altered skin integrity. A review of the resident's clinical record from September 2016 to February 2017, indicated that the resident often exhibited responsive behaviours. A review of the progress notes indicated that when the resident did express responsive behaviours the progress notes did not include documentation of any assessments, reassessments, monitoring and follow-up of the resident. The DOC acknowledged on an identified date in March 2017, that the documentation did not include actions taken to prevent the responsive behaviour and any assessments, reassessments, monitoring or follow up of the resident when they expressed responsive behaviours.
This finding of non compliance was identified during Critical Incident Inspection 2779-000028-16. [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 residents demonstrating responsive behaviours that the behavioural triggers are identified and strategies are developed and implemented to respond to these behaviours and actions are taken to respond to the needs of the resident including assessments, reassessments and interventions and the residents responses to interventions are documented, to be implemented voluntarily.

Issued on this 14th day of June, 2017

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506), LISA VINK (168)
Inspection No. / No de l'inspection :	2017_555506_0009
Log No. / Registre no:	013139-16, 018611-16, 024957-16, 033046-16, 001646-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 24, 2017
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 :	Catherine Donahue

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that a resident at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

1. To ensure that all residents who are at risk of altered skin integrity receive a head to toe skin assessment when they return from any hospitalization.

2. To ensure that all registered nursing staff are educated and aware of the expectation that any residents who return from the hospital and is at risk of altered skin integrity receive a head to toe skin assessment.

3. To create an audit tool to ensure that all residents who return from hospital and are at risk of altered skin integrity receive a head to toe skin assessment.

Grounds / Motifs :

1. Judgement Matrix:
Severity- Potential for harm
Scope- Pattern
Compliance History- Previously issued as a VPC on November 2015

A. Resident #053 was sent to the hospital following an incident, where they sustained an injury on an identified date in November 2016. A review of the clinical record identified that the resident returned from the hospital with an area of altered skin integrity that was sustained during the incident prior to hospitalization, which had been covered with a dressing. A review of the clinical record did not include a head to toe assessment of the resident on return from the hospital. The DOC acknowledged that the resident did not receive a skin assessment upon their return from hospital.
This finding of non compliance was identified during Critical Incident Inspection 2779-000028-16. (Inspector #506)
B. Resident #021 was admitted to the hospital following an incident, where they sustained an injury in 2016. A review of the clinical record identified that at the time that the resident returned, to the home, from hospital they had new areas of altered skin integrity, which were covered with dressings. Interview with RPN #101 verified that they did not complete a skin assessment of the resident on their return from hospital and only changed the dressings and referred the areas to the wound nurse for assessment.
A review of the clinical record did not include a head to toe skin assessment of the resident on return from the hospital, only referred the areas to the wound nurse for assessment. A review of the clinical record did not include a head to toe assessment of the resident on return from the hospital as confirmed by nursing management staff #107.
The resident did not receive a skin assessment upon their return from hospital.
This finding of non compliance was identified during Critical Incident Inspection 2779-000019-16.
(Inspector #168) (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 24th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lesley Edwards

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