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
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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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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	2016_556168_0029	033142-16	Other

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), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 30, 2016, December 1, 8, 9, 22, 2016, February 24, 27, 28, 2017, March 1, 2, 3, 7, and 8, 2017.

This inspection was conducted, in part, concurrently with Complaint inspection, report number 2016_556168_0030, for log number 033487-16.

This inspection was completed regarding nursing and personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the former DOC, the Resident Assessment Instrument (RAI) Coordinator, Staff Educator, Office Manager, the pharmacist, registered nurses (RN) and registered practical nurses (RPN).

During the course of the inspection, the inspectors: observed the provision of care and services, reviewed relevant policy and procedures, reviewed training records, reviewed employee files and schedules, reviewed meeting minutes, reviewed incident reports and reviewed clinical records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Medication
Reporting and Complaints
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

Employee #208 identified themselves as a RPN on the resume which they submitted to the home when they expressed interest to work in a nursing position at the home .
The applicant began employment, in the position of part time RPN, in 2015.
According to the Administrator and the DOC the employee was responsible for the direct care of residents, which included medication administration while they worked in the home in the position of RPN.
A review of electronic Medication Administration Records (eMARs) for residents #30, #31 and #32 verified that the employee administered medications to the residents.
In 2016, it was brought to the attention of the home that the employee's registration status with the College of Nurses of Ontario (CNO) was in question and the employee was put on leave from their position.
The employee no longer was employed by the home at the time of the inspection, after the home received confirmation from the CNO, that they had no indication that the employee was currently, nor ever registered to practice in Ontario.
The employee was not a physician, dentist, RN or RPN.

The home did not ensure that no person administered drugs to residents unless that person was a physician, dentist, RN or RPN, when employee #208 administered medications to residents while they worked at the home. [s. 131. (3)]

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. Resident #038 demonstrated new symptoms according to the clinical record on an identified date in 2015.
The resident's representative requested a test be completed to rule out a diagnosis.
The following day the resident again displayed a symptom and on request the physician was contacted and ordered that the resident be transported to the hospital for assessment.
A review of progress notes on the shift that the resident was transported to the hospital did not include any assessment findings of the resident other than a vital sign recording.
Interview with the former DOC identified that staff member #208 failed to document assessments, interventions and the resident's responses to interventions following a review of the clinical record.

B. Resident #036 had a change in condition and received comfort care, a few days before passing away at the home, with family in attendance.
A review of the clinical record identified that the day prior to the residents death, staff member #208 provided care to the resident, as a charge staff on the unit.
The staff member failed to document any assessment of the resident, interventions provided or the resident's response and only recorded the amount of a specific medication consumed by the resident during the shift.
Interview with the former DOC verified that based on the anticipated care needs of the resident, at the time that care was provided by staff #208, it was the expectation that staff member document their assessment findings and interventions to communicate the needs and status of the resident.
The former DOC verified that the assessment findings, interventions provided and the resident's response to interventions were not documented as required.

C. A review of resident #024's clinical record indicated that the resident returned home from the hospital with an injury from an incident on a specified date in 2016. A review of the progress notes did not include documentation of the fall or that the resident was transported to the hospital. Interview with the former DOC acknowledged that RPN #212 failed to document assessments, interventions and the resident's responses to interventions following a review of the clinical record. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee failed to ensure that all staff of the home had the proper skills and qualifications to perform their duties, and the qualifications provided for in the regulations.

The interpretation of "registered practical nurse" (RPN) according to the LTCHA, 2007 identifies an RPN as a member of the College of Nurses of Ontario (CNO) who holds a certificate of registration as a registered practical nurse under the Nursing Act 1991. Ontario Regulation 79/10 section 46 identifies that the licensee shall ensure that every member of the staff who preforms duties in the capacity of registered nurse, registered practical nurse, or registered nurse in the extended class has the appropriate current certificate of registration with the CNO.

The practice of hiring registered nursing staff, used by the home prior to the incident with employee #208, was discussed with the Administrator.
It was identified by the Administrator their past practice, prior to interviewing an applicant for a registered nursing position included a check of the applicants status on the CNO "Find a Nurse" website to ensure that the applicant was a member in good standing; however, documentation of this information was not consistently maintained.

Employee #208 identified themselves as a RPN, who completed the Practical Nursing Program at college in Ontario, on their resume which they submitted to the home.
The home was not able to produce a record that they conducted a search on the CNO "Find a Nurse" website for the employee.
The applicant began employment at the home, in the position of part time RPN, in 2015.
According to the Administrator and the DOC, employee #208 was responsible for the direct care of residents while they worked in the home in the position of RPN.
In 2016, it was identified that the employees status with the College of Nurses of Ontario (CNO) was in question and the employee was put on leave from their position.
The employee no longer was employed by the home at the time of the inspection, after the home received confirmation from the CNO, that they had no indication that the employee was currently, nor ever registered to practice in Ontario as an RPN.

The home did not ensure that employee #208 had the qualifications to perform their duties or the qualifications provided for in the regulations. [s. 73.]

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 of the home have the proper skills and qualifications to perform their duties, and the qualifications provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed and corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

The Administrator and RAI coordinator identified that a record of all individual medication incidents and adverse drug reactions were located in Point Click Care, in the Risk Management section.
Risk Management Incident Reports for medication incidents were reviewed and these reports included some specific information regarding the incidents, specifically but not limited to: who prepared the report, the resident involved, a description of the incident, actions taken post incident, an assessment of the resident and predisposing factors.
The Risk Management Incident Reports did not include an analysis of the incident nor consistently the identification of staff involved in the incident and/or actions taken to address the issue.
Interview with the former DOC identified their practice of recording hand written notes on the incident reports for their analysis of the incident and actions taken.
Hard copy incident reports were provided for 2015 and 2016.
A review of the 2015 reports identified that a number of the reports did not include notes by the former DOC to support an analysis of the incident or actions taken as a result.
The former DOC reviewed a sample of incident reports from 2015, specifically for residents #030, #060, # 068 and #069 and verified that there was no documentation on the reports to include an analysis of the incidents nor actions taken. It was also stated that other than specific employee files, when discipline occurred, there would be no other records of actions taken as a result of an medication incident.
Interview with the Administrator identified that as per their discussion with corporate staff the home should have requested a pharmacy incident review/report for each medication incident which occurred and not just those for which the pharmacy was responsible for, which was their past practice.
The current DOC identified that they had reviewed each medication incident for 2015 and 2016 and identified the staff involved in each incident. The current practice in the home includes to document each medication incident, including an analysis of the incident and follow up actions completed.

The home did not ensure that for each medication incident and adverse drug reactions a written record was kept of everything required for an analysis of the incident and the corrective action taken. [s. 135. (2)]

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 medication incidents and adverse drug reactions are documented, reviewed and analyzed and corrective action is taken as necessary, and a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

Issued on this 30th day of May, 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) :	LISA VINK (168), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2016_556168_0029
Log No. / Registre no:	033142-16
Type of Inspection / Genre d'inspection:	Other
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:

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. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee shall ensure that no person administers a drug to a resident unless that person is a RN, RPN, dentist or physician.

The licensee shall ensure that there is a process in place, which is followed, to ensure that all persons who administer drugs to residents are a RN, RPN, dentist or physician.

Grounds / Motifs :

1. This Order was based upon 3 factors: severity, scope and history of non-compliance in keeping with section 299(1) of Ont.Regulation 79/10. The severity was 2 (minimal harm or potential for harm/risk), the scope was three (widespread) and the compliance history was 3 (previously related non-compliance).

The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

Employee #208 identified themselves as a RPN on the resume which they submitted to the home when they expressed interest to work in a nursing position at the home .
The applicant began employment, in the position of part time RPN, in 2015.
According to the Administrator and the DOC the employee was responsible for the direct care of residents, which included medication administration while they worked in the home in the position of RPN.
A review of electronic Medication Administration Records (eMARs) for residents #30, #31 and #32 verified that the employee administered medications to the residents.
In 2016, it was brought to the attention of the home that the employee's registration status with the College of Nurses of Ontario (CNO) was in question and the employee was put on leave from their position.
The employee no longer was employed by the home at the time of the inspection, after the home received confirmation from the CNO, that they had no indication that the employee was currently, nor ever registered to practice in Ontario.
The employee was not a physician, dentist, RN or RPN.

The home did not ensure that no person administered drugs to residents unless that person was a physician, dentist, RN or RPN, when employee #208 administered medications to residents while they worked at the home. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 09, 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 : LISA VINK

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