Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 15, 2019	2019_695156_0002	027240-18, 027542-18, 028981-18, 032042-18, 032200-18, 000979-19, 001854-19, 001856-19, 001857-19, 001858-19, 001860-19, 001861-19, 002297-19, 002298-19, 002299-19, 003675-19, 009120-19	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

CAROL POLCZ (156), CYNTHIA DITOMASSO (528), EMMY HARTMANN (748), LESLEY EDWARDS (506)

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): May 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, 29, 30, 31, June 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 24, 2019.

Please note non-compliance related to LTCHA s. 6(5) identified during inspection of complaint log #007048-19, inspection #2019-539120-0021 was conducted at the time of this complaint/follow-up inspection and is included in this inspection report.

Please note the following intakes were inspected during this Complaint/Follow-up inspection:

The following complaint inspections were conducted at the time of the complaint inspection:
027240-18 related to staffing, transferring and continence care
027542-18 related to consent to treatment
028981-18 related to availability of supplies, continence care
032042-18 related to availability of supplies, continence care and menu planning
000979-19 related to alleged abuse
009120-19 related to personal support services
032200-18 related to availability of supplies, alleged abuse and bathing

The following Compliance Order follow ups were conducted at the time of the Complaint inspection:
001860-19 related to s. 76 (2) staff training
001857-19 related to r. 36 safe transferring and positioning
002299-19 related to r. 54 responsive behaviours
003675-19 related to r. 50 (2) skin and wound
001854-19 related to r. 50 (2) skin and wound
001858-19 related to r. 31 (3) staffing
001861-19 related to r. 131 (2) medication administration
001856-19 related to s. 19 (1) prevention of abuse
002298-19 related to s. 6 (10) plan of care
002297-19 related to s. 8 (1) policies and procedures

Non-compliance related to LTCHA s. 6(1)(a) identified during inspection of critical incident system log # 005610-19 is included in this inspection report and has been issued as a voluntary plan of correction.

Non-compliance related to LTCHA s. 6(7) identified during inspection of critical incident system log # 027156-18 and 005610-19 is included in this inspection report and has been issued as a voluntary plan of correction.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, (DOC), Assistant Directors of Care (ADOC), Social Worker, Director of Programs and Support Services, Director of Business Services, Director of Culinary Services, Director of Environmental Services, Employee Services Coordinator, Resident Assessment Instrument (RAI) Coordinator, physician, pharmacy technician, registered staff (registered nurses, and registered practical nurses), personal support workers (PSW's), recreation staff, maintenance, dietary aides, physiotherapist, APANS corporate staff, agency registered and PSW staff, regional owner of Plan A agency, Pinkerton Security company, residents and family members.

During the course of the inspection, the Inspector(s) toured the home, completed observations of the provision of care, medication administration, reviewed resident clinical records, the homes policies and procedures, the homes investigation notes and staff training records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Food Quality
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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

- **12 WN(s)**
- **5 VPC(s)**
- **6 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #006	2018_695156_0006	506
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #008	2018_695156_0006	528
O.Reg 79/10 s. 31. (3)	CO #002	2018_695156_0006	528
O.Reg 79/10 s. 50. (2)	CO #001	2017_689586_0013	506
O.Reg 79/10 s. 50. (2)	CO #005	2018_695156_0006	506
O.Reg 79/10 s. 54.	CO #003	2018_556168_0011	528

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	Légende 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. 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

On an identified date in June, 2019, resident #025 was observed to be in their room with

a treatment applied.
The following day, resident #025 was observed to be in their room with the treatment applied. PSW #129 indicated that the treatment was a part of the resident's care and that they had applied the treatment on the resident.

During an interview with RPN #143, they acknowledged that the treatment was a part of resident #025's planned care. RPN #143 reviewed resident #025's doctor's orders and verified that the resident did not have an order for the treatment they were receiving.

During an interview with the Director of Care (DOC), it was identified that when a resident was assessed for the treatment, a treatment order from the doctor would be obtained that would include specific directions for the resident. The treatment order would be included in the resident's care plan for directions for staff related to the treatment. The DOC acknowledged that resident #025 did not have a treatment order for the treatment they were receiving.

The licensee failed to ensure that there was a written plan of care for resident #025's identified treatment that set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A review of the clinical record for resident #041 for the time period January, 2018 to June, 2019, identified progress notes related to the application of an identified treatment to the resident nineteen different times. The resident did not have a treatment order for the treatment they were receiving as confirmed with the RAI Coordinator. [s. 6. (1) (a)]

3. The licensee failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Resident #002 was observed in their room, with an intervention in place on an identified date in May, 2019. In a review of resident #002's care plan, this identified intervention was not included.

During an interview with registered staff #110, it was identified that the intervention was not a new intervention for resident #002. Registered staff #110 reviewed resident #002's care plan and verified that the intervention was not included.

Interview with the DOC verified that the intervention that was being applied on resident #002 should have been included in their plan of care.

The licensee failed to ensure that there was a written plan of care for resident #002 that set out the planned care for the resident.

This area of non compliance for resident #002 was identified and moved to this inspection report as a result of CIS inspection conducted simultaneously. [s. 6. (1) (a)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were consistent with each other.

The plan of care for resident #001 identified that the resident had an altercation with a co-resident in December 2018. As a result, an intervention was implemented.

Review of the plan of care identified that the intervention was in place from designated times to monitor the resident and prevent further incidents.

Review of the progress notes identified that on an identified date in December, 2018, the resident expressed displeasure with the new intervention. Disclosure meeting notes dated January, 2019, were reviewed and documented that the resident and their substitute decision maker (SDM) expressed dissatisfaction with having the intervention for an identified amount of time. A complaint letter submitted from the family of resident #001 to the home on an identified date in January, 2019, included concerns. During interview with the resident during the course of the inspection, they stated that they were told by the home that the purpose of the intervention was to prevent further incidents, and that they were unhappy with the intervention.

In an interview with the Administrator and DOC, and review of disclosure meeting notes, it was confirmed that the identified intervention was not consistent with the interventions developed for those providing the care intervention. [s. 6. (4) (a)]

5. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Review of a complaint intake from January 2019, outlined concerns of resident #001 not

being notified of changes in their plan of care.

A) On an identified date in January, 2019, as a result of an incident where resident #001 placed a co-resident's safety at risk, an intervention was put in place, which was to be re-evaluated in one month's time and as needed.

Interview with the Administrator and DOC on an identified date in May, 2019, they stated that they had seen an improvement in the residents civility with co-residents.

In February, 2019, the resident and their SDM met with the Administrator and DOC for a re-evaluation of the intervention. Review of meeting notes taken by the DOC, identified that both the resident and their SDM indicated that they wanted the intervention to stop and that it was not common ground. Interview with the Administrator confirmed that at the re-evaluation meeting, despite the resident and SDM's statements, no changes were made to the intervention and it remained in place after that meeting. Interview with three staff in the home, who requested to be anonymous, confirmed that the resident had a reaction with the intervention in place. Interview with the resident, throughout the course of the inspection, confirmed that they had concerns with the intervention in place.

Resident #001 was not included in the development and implementation of their plan of care related to the re-evaluation of their intervention in February, 2019.

B) Review of the plan of care for resident #001 identified that the resident required the assistance of staff for bathing and had known preferences.
i) Review of the bathing schedule for April 2019, identified that the resident was scheduled on an identified bathing shift twice a week. Interview with resident #001, staff #145 and #142 confirmed that the resident usually had regular staff assist them with bathing and that the resident was not included in the changes made to the bathing schedule in April 2019, which upset the resident.
ii) A progress note dated on an identified date in May, 2019, documented the resident preferred to have a bath at an identified time and did not want agency staff to assist them with bathing.
iii) Interview with the DOC confirmed that in April 2019, a new bathing schedule was created to assist with the home ensuring that all residents were bathed. The DOC stated that they were unaware of the change to the resident #001's bathing routine when the new schedule was created. Interview with the ADOC confirmed that after the changes in the resident's bathing schedule, they met with the resident on an identified date in May, 2019, and updated the plan of care and bathing schedule to reflect the resident's

preferences for bathing.

The resident was not provided an opportunity to participate fully in changes in their plan of care, related to bathing, until after the changes had been made.

C) Review of the plan of care for resident #001 included a progress note from January 2016, which documented that the resident stated they could not complete an activity under identified circumstances. A physician order from April, 2016, directed staff to allow the resident to complete an activity. Interview with staff #142 confirmed supplies would be left with the resident to complete the activity.

i) A progress note dated in March, 2019, documented changes to the resident's care needs including, no longer providing supplies for the resident to complete the activity.
ii) Interview with ADOC #200 confirmed that as a result of unsafe practices, changes to the resident's orders were implemented immediately and the resident was notified of the changes.
iii) On an identified date in March, 2019, family of the resident expressed concerns, on behalf of the resident, to the Administrator in an email related to the changes in practices.
iv) On an identified date in April, 2019, a new physician order was written to leave the supplies with the resident to complete the activity but to return in five to ten minutes to ensure safe completion. A progress note dated April, 2019, confirmed that the resident was happy with the new physician order.
v) Interview with ADOC #200 confirmed that the unsafe practices were identified on a March, 2019 evening and therefore, the changes to the practices were implemented immediately. The ADOC also confirmed it wasn't until the following week that the resident was included in the decision making. Interview with staff #142 and the physician confirmed that the resident was upset that orders were abruptly changed on an identified date in March, 2019, and that the resident was not included in the development in the plan of care until after changes were made.

The resident was not included in the implementation of their plan of care related to changes in their care.

D) In January, 2019, as a result of an incident where resident #001 placed a co-resident's safety at risk, resident #001 had interventions put in place. The interventions included but was not limited to measures to prevent a re-occurrence. The interventions included that any further incident would result in the immediate termination of an

identified personal item while the incident was under investigation. A different item will be reinstated as well as a care provider for four hours a day

i) On the morning of an identified date in May, 2019, at approximately 1045 hours, the resident approached LTC Home Inspector #528 to notify them of an incident that occurred where they had contact with an identified staff member. The resident referred to a second staff member who witnessed the incident, staff #141. Interview with staff #141 confirmed that the incident appeared accidental.
ii) As a result of the incident, the police were called to the home to conduct an investigation. Approximately two hours after the incident, the Administrator, confirmed that they had called the police and had indicated that they had not spoken to the resident but would be doing so later that day.
iii) Subsequently, the resident had indicated that the management had not spoken to them on the day of the incident other than written correspondence on the evening of an identified date in May, 2019, requesting a meeting for an identified date in May, 2019, to discuss the event. The resident indicated that after the police were called, they were unsure of the home's actions. They expressed concern due to the intervention in place The resident stated, which was confirmed by progress notes, that they spent a specific period of time in a position/location with specific care provided by staff as needed.
iv) In a follow up interview with the Administrator on an identified date in May, 2019, they indicated that they had gone down to see the resident at the end of the day on an identified date in May, 2019, but the resident was not available for an interview and confirmed no one from the home had spoken to the resident about the incident, other than the police officer. They also confirmed that the manager on call was not notified that the resident had concerns. Interview with the physician on an identified date in May, 2019, identified they were concerned that the home had not spoken to the resident resulting in the resident's positioning/location for an identified period of time.

The resident was not included in the development and implementation of their plan of care when an incident occurred.

E) Review of the plan of care for resident #001 identified that they had a potential for specific responsive behaviours.

i) During the course of the inspection, resident #001 had identified a request related to their care conference in January, 2019.
ii) Interview with two identified staff members confirmed that at the care conference, the request was not honoured. Interview with the identified staff members confirmed the

request for the preference at the care conference.
iii) Interview with the identified staff reported that they were unaware of the request related to the conference in January, 2019. In addition, they stated that the resident and SDM were upset at the conference.
iv) Interview with three staff in the home confirmed that they were aware of the resident's preference prior to the care conference in January, 2019.
v) Interview with ADOC #200, who was not working in the home at the time of the care conference, confirmed that if any resident made the specific request, the request would be respected. ADOC #200 also indicated that there had been circumstances where other actions were taken to meet an identified need.

The resident was not included in the development of the plan of care related to their care conference in January, 2019.

F) Review of a complaint submitted in October 2018, identified care concerns related to resident #001. In a follow-up conversation with the complainant in March 2019, they outlined additional concerns related to the resident not being provided their full plan of care.

i) The homes policy Access to Health Records/Copies of Heath Records/Release of Information, dated July 2016, indicated that the resident was entitled to copies of their health and medication records, with documented consent, APANS approval; and the suggested fee to be charged would be $0.15 per copy.
ii) Review of email correspondence from the complainant to the Administrator, confirmed that in January 2019, the complainant indicated that the resident would like a copy of their chart. On an identified date in January, 2019, the Administrator informed the complainant of the process the resident was to follow to request a copy of their medical record, noting residents and staff names would be redacted, resulting in an administrative fee.
iii) On an unidentified date, resident #001 requested a copy of their medical records including progress notes. Interview with the resident during the course of the interview, stated that the home removed all staff names from their medical record and was charged greater than $100.00 for the copy. Email correspondence dated March, 2019, from the Administrator, confirmed that the home had redacted the names of persons completing the charting, as directed by corporate office, and was reflected in the fee.
iv) Interview with the DOC on an identified date in May, 2019, confirmed that they had redacted the staff names from the resident's medical record as directed by the licensee; and then charged the resident for their time. Interview confirmed that the resident and

family were upset with the redaction and requested the full record, which the home then supplied after approval from their corporate office.
v) The home was unable to provide a receipt for the purchase of; however, the DOC confirmed that the resident was charged more than the suggested amount in the policy for copies if this health care record because of the time it took to complete the task.
vi) On an identified date in March, 2019, after the resident and family expressed concerns to the home, a copy of the chart without the redaction was provided to the resident, the resident confirmed they paid an identified amount for the chart.

The resident was not included in the development and implementation of their plan of care when they were not provided full access to their health record, including staff names who provided care to the resident. [s. 6. (5)]

6. The plan of care for resident #002 identified that they required assistance with bathing.

i) On an identified date in June, 2019, the SDM for resident #002 stated that they were not consulted prior to the changes made to the bathing schedule in April 2019, and that the resident's bathing times had changed.

ii) Interview with the DOC, confirmed that changes to the home areas bathing schedule were based off the previous schedule; however, changes did occur to some of the scheduled baths. Interview with ADOC #200 and the DOC confirmed that residents and families were consulted after the changes were made.

The SDM for resident #002 was not provided the opportunity to participate fully in the development of the plan of care, related to the bathing schedule. [s. 6. (5)]

7. Review of a complaint intake submitted in October 2018, identified concerns related to consent for treatment given to resident #010.

A) Review of the plan of care for resident #010, identified that the resident had a cognitive status. A progress note dated in September, 2018, documented consent was given by the SDM for an identified assessment. Review of a consultation note dated September, 2018, identified that the resident received a treatment from an external physician. A complaint response letter dated October, 2018, confirmed that consent was obtained for assessment only and not obtained for the treatment. Interview with RPN #143 confirmed that consent was not obtained for the treatment administered in

September 2018.

B) Review of the plan of care for resident #013 identified that the resident had a cognitive status. Review of a progress note on an identified date in September, 2018, included documentation that consent was obtained from the resident's SDM for an identified assessment. Review of a consultation note dated September, 2019, identified that the resident received an identified treatment. Interview with RPN #143 confirmed that consent was not obtained related to the treatment administered in September 2018.

LTC Home Inspector #130 interviewed the Administrator, at which time, the Administrator confirmed that consent was not obtained for approximately ten residents related to treatments given in September 2018. [s. 6. (5)]

8. On an identified date in March, 2019, resident #044 experienced a change in condition related to their overall health. The resident presented with identified symptoms within an eight-hour period. The condition could not be linked to any medication use or dietary issues. The resident was seen by a physician and received medication later in the evening. The SDM was notified on the same date that medication was being administered and that the resident had an unexplained symptom.

At the same time, the home was officially in an outbreak. The outbreak included all residents who had two or more identified symptoms within a 24-hour period. The resident was therefore placed into isolation (confined to their room) beginning on an identified date in March, 2019. The resident's SDM reported that they were not informed that the resident was in isolation for outbreak symptoms until another identified date in March, 2019.

A review of the resident's clinical records did not include any notes to indicate that the SDM was informed about the resident's change in condition related to their health. Interviews with registered staff #142 and #221, revealed that although they spoke to the SDM on a daily basis to update them about the resident's condition, no one informed the SDM that the resident was also in isolation due to outbreak symptoms. The SDM therefore was not given an opportunity to discuss what the registered staff were doing for the resident and whether or not the SDM agreed with the course of action. (120) [s. 6. (5)]

9. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for resident #001 identified that the resident had a history of specific responsive behaviours. Interventions directed staff and included not to invade the resident's personal space, and if strategies were not working to re-approach resident in five to ten minutes. A progress note from November, 2018, documented an incident of a responsive behaviour toward an identified staff member. In an interview with the identified staff in May, 2019, they stated that they had only three verbal interactions with the resident and they were all negative. They had stated that they were trying to keep their distance from the resident.

On the morning of an identified date in May, 2019, at approximately 1045 hours, the resident approached LTC Home Inspector #528 to notify them of an incident that occurred where they had accidental contact with the identified staff member. The resident referred to a second staff member who witnessed the incident, staff #141. Interview with staff #141 confirmed that the incident appeared accidental. The resident had reported to the LTC Home Inspector #528 their account of the incident. The staff member, during an interview verbalized their account of the incident, which included prior to the contact that the resident was upset.
Noting the conversation with the identified staff member in May, 2019, in which they stated they were "keeping their distance" from resident #001, and a similar incident from November 2018; in May, 2019, the identified staff member did not follow the resident's plan of care to re-approach the resident in five to ten minutes when the resident displayed specific responsive behaviours. [s. 6. (7)]

10. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of resident #017's care plan indicated for a treatment to be applied to resident #017 as per doctor's orders.

A review of resident #017's doctor's orders identified that resident was to receive the treatment.

In June, 2019, inspector #748 observed PSW #108 and PSW #111 perform personal care without the treatment on the resident. The treatment was not applied to resident #017 until ten minutes later. PSWs #108 and #111 acknowledged that they did not apply the treatment on resident #017 while they performed the personal care on the resident.

On another identified date in June, 2019, inspector #748 observed that resident #017 was applied the treatment. After approximately 14 minutes, inspector #748, observed PSW #104 check the treatment; however, it was not administered as directed. PSW #104 acknowledged that the treatment should have been administered as ordered.

During an interview with registered staff #110, the resident's care plan and doctor's orders were reviewed, and registered staff #110 verified that resident #017's treatment should be on at all times, including when the resident was being provided care.

The licensee failed to ensure that resident #017 was provided with the treatment at all times, as specified in the plan of care. [s. 6. (7)]

11. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Critical Incident System (CIS) was submitted to the director, for alleged neglect of resident #002 by staff that resulted in harm or a risk of harm to the resident.

In review of resident's care plan, it was noted that staff were to remain with resident #002 when they were in the bathroom to ensure safety.

During an interview with PSW #129, it was identified that they were assigned to resident #002 when the resident was found on the floor on an identified date in March, 2019. PSW #129 indicated that they had left resident on the toilet to assist another person.

During an interview with the DOC, it was verified that PSW #129 did not follow resident #002's plan of care on the identified date in March, 2019.

The licensee failed to ensure that staff remain with resident #002 when they were in the bathroom to ensure their safety, as specified in the resident's plan of care.

This area of non compliance for resident #002 was identified and moved to this inspection report as a result of CIS inspection conducted simultaneously. [s. 6. (7)]

12. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #040 was identified at risk for falls. The resident sustained a fall in June, 2019

and sustained injury. The care plan for the resident indicated that staff were to ensure that an identified intervention was in place at specific times. A review of the clinical record for the resident indicated that the resident did not have the intervention in place at the time of the fall. The care set out in the plan of care was not provided to the resident as specified in the plan as confirmed with the RAI Coordinator in June, 2019. [s. 6. (7)]

13. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of the plan of care for resident #003 identified that the resident exhibited responsive behaviours. The Minimum Data Set (MDS) Assessments from January and April 2018, identified that the resident's behaviour status had deteriorated and in June 2018, the resident was referred to Behavioural Supports Ontario (BSO).

Review of the plan of care identified that resident #003's responsive behaviours continued in July and August 2018, and as part of the plan of care, an intervention was implemented daily to monitor resident and prevent altercations with co-residents.

i) From September to October 2018, four critical incident reports were submitted to the MOHLTC, outlining physical altercations between resident #003 and co-residents, that resulted in no injuries.

ii) Review of a Critical Incident report identified that in September, 2018, resident #003 had an altercation with co-resident #004 with no injuries. Interview with RPN #139 confirmed that the intervention was not in place monitoring the resident at the time of the incident. RPN #139 confirmed that care was not provided to the resident as specified in their plan.

iv) On identified dates in September and October, 2018, the resident had altercations with co-residents #004, #005 and #006. CIS reports submitted to the MOHLTC, identified that residents were not injured as a result of the incidents.

Interviews with RPN #130 and #105, who were working in the home at the time of the altercations identified that the intervention, did not prevent altercations with co-residents and therefore, did not provide the care to the resident as specified in the plan, related to responsive behaviours. (528)

This area of non compliance for resident #003 was identified and moved to this

inspection report as a result of CIS inspection conducted simultaneously. [s. 6. (7)]

14. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and any other time when, the resident's care need changed or care set out in the plan was no longer necessary.

Resident #041 was identified at risk for falls. The resident sustained a fall in June, 2019 and sustained an injury. The resident was given medication. The following day, the progress notes indicated a treatment was applied. The treatment was ordered on an identified date in June, 2019, however, a review of the care plan did not include the application of the treatment. The resident's plan of care was not reviewed and revised when the resident's care needs had changed in relation to the application of the treatment as confirmed with the RAI Coordinator. [s. 6. (10) (b)]

15. The licensee failed to 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 need change or care set out in the plan was no longer necessary.

Resident #038 was identified at risk for falls. The resident sustained a fall on an identified date in May, 2019, and sustained an injury and was subsequently taken to the hospital. The resident returned at approximately 1900 hours the same day with a change in condition. The resident had a physiotherapy assessment and physiotherapy was to be started twice per week. The resident complained of pain on an identified date and received as needed (PRN) medication. The plan of care for resident #038 did not include any changes of the above interventions, reassessment of goals or any new interventions following the fall. The plan of care was not updated to reflect the resident's care needs had changed in relation to the fall as confirmed with registered staff #142.

This non-compliance was further evidence to support order #001 from inspection 2018_556168_0011. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 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 there is a written plan of care for each resident that sets out the planned care for the resident; and to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are consistent with each other; and, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Park Lane Terrace is a long-term care home with a licensed capacity of 132 beds with approximately 24 to 30 residents in each of the five home areas.

The master daily rosters were provided for five weekends from specified dates in May to June, 2019, by the Employee Services Coordinator on request.

A review of the daily rosters for the weekend shifts (15) indicated that over the identified time period there were nine occasions where an agency RN staff was on duty and there was not a member of the regular RN nursing staff of the home on duty and present in the home at all times.

Nine out of 15 shifts (60%) did not have a member of the regular RN nursing staff of the home on duty and present in the home at all times as confirmed with the Employee Services Coordinator. [s. 8. (3)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

1. The Administrator reported that the process for agency staff was to come into the home one hour prior to their shift and to complete the orientation package and the Safe Assessment Lift Transfer (SALT) training prior to their shift. The Administrator provided a copy of orientation package to the inspector.

The following agency staff worked in the home since the compliance due date of April 15, 2019, from the compliance order issued during the Resident Quality Inspection (RQI) 2018_695156_0006 and did not receive the required orientation training as noted above prior to working their first shift as confirmed with the Administrator:

a) Agency PSW staff #112 worked four shifts in April, 2019, as confirmed with the Employee Service Coordinator. The staff did not receive the required orientation training until after the identified shifts as reported by the Administrator.

b) Agency PSW staff #114 worked two shifts in total in April and May, 2019, as confirmed with the Employee Service Coordinator. The home was unable to produce any training records as reported by the Administrator.

c) Agency PSW staff #119 worked five shifts in total in April and May, 2019, as confirmed with the Employee Service Coordinator. The staff did not receive the required training until after the identified shifts as reported by the Administrator.

d) Agency PSW #200 worked a shift in April, 2019 however, the home was unable to produce any orientation training as reported by the Administrator.

e) Agency PSW staff #203 worked a shift in April, 2019 however, the home was unable to produce any orientation training as reported by the Administrator.

f) Agency PSW staff #205 worked a shift in April, 2019 however, the home was unable to produce any orientation training as reported by the Administrator.

g) Agency PSW #120 did not have SALT training prior to working their first shift in April, 2019 and had not completed training as of an identified date in June, 2019, as confirmed by the Employee Service Coordinator. The staff worked five additional shifts, in total, in April and May 2019 as confirmed with the Employee Service Coordinator. The staff received the orientation training package on an identified date in April, 2019 however, the training record was not maintained in the home as confirmed with the Administrator.

2. The Administrator reported that the home currently only uses "Plan A" agency. The regional owner of this agency was contacted and reported that they provide their staff with an online training portal that they must complete prior to working any facility as agency staff. The training portal was reviewed and did not contain home specific

policies.
The Administrator provided a copy of the LTC home's orientation package provided to agency staff to complete prior to the completion of their first shift. The package did not contain the home's policy to minimize the restraining of residents; infection prevention and control; emergency and evacuation procedures as confirmed with the Administrator.

3. An identified employee began their employment on an identified date in April, 2019, and completed their first shift approximately one week later as confirmed with the DOC. The employee completed the required training by the time of their first shift with the exception of infection prevention and control as confirmed with the Administrator.

4. The home was previously ordered during RQI inspection 2018_695156_0006 to maintain a record of all agency staff training. As confirmed with the Administrator, the home did not have any orientation training records for the following agency staff:

a) Agency RN #128 received orientation training in December, 2018. The staff worked in May, 2019, as confirmed with the Employee Service Coordinator, however, the orientation training record was not maintained in the home as confirmed with the Administrator.

b) Agency RPN #117 received orientation training in December, 2018. The staff worked in April, 2019, as confirmed with the Employee Service Coordinator, however, the orientation training record was not maintained in the home as confirmed with the Administrator.

c) Agency RPN #115 received orientation training in January, 2019. The staff worked five shifts in total in April and May, 2019 as confirmed with the Employee Service Coordinator. The Administrator reported that the orientation training was not completed until completion of their second shift in April, 2019, and there was no record of the completion of the SALT training.

d) Agency PSW #118 received orientation training in January, 2019. The staff worked ten additional shifts in total in April and May, 2019, as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

e) Agency PSW #121 received orientation training in February, 2019. The staff worked seven shifts in total in February, April and May, 2019 as confirmed with the Employee

Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

f) Agency PSW #116 received orientation training in February, 2019. The staff worked five shifts in total in February, April and May, 2019, as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

g) Agency PSW #131 received orientation training in February, 2019. The staff worked two shifts in total in February and April, 2019, as confirmed with the Employee Service Coordinator, however, the orientation training record was not maintained in the home as confirmed with the Administrator.

h) Agency RPN #124 received orientation training in February, 2019. The staff worked four shifts in total in February, April and May, 2019 as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

i) Agency RPN #127 received orientation training in February, 2019. The staff worked five shifts in total in February, April and May, 2019, as confirmed with the Employee Service Coordinator. The Administrator reported that the staff did not complete the SALT or orientation training package until an identified date in May, 2019.

j) Agency PSW #122 received orientation training in March, 2019. The staff worked five shifts in total in March, April and May, 2019, as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

k) Agency RN #126 received orientation training in March, 2019. The staff worked three shifts in total in March and May, 2019 however, the home did not receive the record of the required training until an identified date after the shifts in May, 2019, as reported by the Administrator.

l) Agency PSW #113 received orientation training in March, 2019. The staff worked seven shifts in total in March, April and May, 2019, as confirmed with the Employee Service Coordinator. The home did not receive the record of the required training until identified dates in May, 2019, as reported by the Administrator.

m) Agency PSW #125 received orientation training in April, 2019. The staff worked six shifts in total in April and May, 2019, as confirmed with the Employee Services Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

n) Agency PSW #123 received orientation training in April, 2019. The staff worked two shifts in total in April and May, 2019, as confirmed with the Employee Services Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

o) Agency PSW #133 received orientation training in November, 2018. The staff worked three shifts in total in November, 2018, April and May, 2019, as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

p) Agency PSW #206 received orientation training in August, 2018. The staff worked four shifts in total in August, 2018, April and May, 2019 as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator. [s. 76. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services. Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

1. In accordance with O. Reg 79/10, s. 48 (1) 1 and in reference to O. Reg s. 49 (2), the licensee is required to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the licensee's Post Fall Algorithm 5.2 which was part of the licensee's Falls Prevention Policy last revised May 2018, and completion of the Head Injury Routine (HIR) last revised May 2019 which was part of the policy.

The Post Fall Algorithm identified that when a resident sustained a fall staff were to: communicate fall risk to other care staff; place a falling star logo at bedside/wheelchair/walker.

The policy identified that a HIR would be initiated for all resident falls that were not witnessed and for witnessed resident falls that included the possibility of a head injury.

A) Resident #032 was identified at risk for falls. According to the clinical record, the resident sustained a fall in May, 2019.

i) Observation of the resident, in June, 2019, and their room verified that the falling star logo was not in place for the resident as confirmed by PSW's #151 and #103.

ii) A review of the clinical record, for the fall of the identified date in May, 2019, did not include a completion of the HIR as required. Documentation of the HIR was completed on identified scheduled times; however, not fully completed. In June, 2019, registered staff #105, following a review of the clinical record verified that the HIR was not documented as completed at the frequency required for the resident post fall.

B) Resident #038 was identified at risk for falls. The resident sustained a fall on an identified date in May, 2019, and sustained an injury.

i) A review of the clinical record, for the fall in May, 2019, did not include a completion of the HIR as required. Documentation of the HIR was only completed on two identified times. On an identified date in June, 2019, registered staff #142, following a review of the clinical record verified that the HIR was not documented as completed at the frequency required for the resident post fall.

ii) Observation of the resident, on an identified date in June, 2019, verified that the falling star logo was not in place for the resident as confirmed by registered staff #142 and PSW staff #144.

C) Resident #040 was identified at risk for falls. The resident sustained a fall on an identified date in June, 2019 and sustained an injury.

A review of the clinical record, for the fall of the identified date in June, 2019, did not include completion of the Head Injury Routine (HIR) as required. Documentation of the HIR was completed on identified scheduled times; however, not fully completed. On an identified date in June, 2019, interview with the RAI Coordinator, following a review of the clinical record verified that the HIR was not documented as completed at the frequency required for the resident post fall.

D) Resident #041 was identified at risk for falls. The resident sustained a fall on an identified date in June, 2019 and sustained an injury.

A review of the clinical record, for the fall in June, 2019, did not include a completion of the Head Injury Routine (HIR) as required. Documentation of the HIR was completed on identified scheduled times; however, not fully completed. On an identified date in June, 2019, interview with the RAI Coordinator, following a review of the clinical record verified that the HIR was not documented as completed at the frequency required for the resident post fall.

2. In accordance with O. Reg. 79/10 s. 114 (2) the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the home did not comply with the home policy "Medication Administration" IIA01 dated July 12, 2018, indicated under Documentation that when PRN medications are administered, the following documentation is provided on the electronic Medication Administration Record (eMAR): date and time of administration, dose, route of administration (if other than oral), and if applicable the injection site; complaints or symptoms for which the medication was given; results achieved from giving the dose and time results were noted; documentation of person recording administration and documentation of person recording effects, if different form the person administering the medication.

A) Resident #038 was identified at risk for falls. The resident sustained a fall on an identified date in May, 2019 and sustained an injury.

The clinical record including the eMAR and progress notes were reviewed. On an identified date in May 2019, progress notes indicated that PRN medication was administered to resident #038 as the resident complained of pain following the fall. Interview with registered staff #142 confirmed that the administration of the medication was not documented. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted a CI report in May, 2019, reporting improper/incompetent treatment to a resident that resulted in harm or risk to a resident. On an identified date in May, 2019, resident #011 was receiving care from PSW #121. The resident was left unattended in an unsafe position by the PSW. When left unattended, the resident sustained a fall which resulted in injury. PSW #121 confirmed that they did not use safe transferring and positioning techniques when assisting resident #011 when they left the resident unattended in the position which resulted in the resident sustaining a fall.

It was noted that the staff did not have the required SALT training until an identified date in May, 2019, as confirmed with the Employee Service Coordinator. [s. 36.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may have occur, immediately reported the suspicion and the information upon which it was based to the Director.

In January, 2019, the family of resident #001 emailed a written complaint to the Administrator of the home. The email expressed concerns and alleged abuse resulting in a decline of the residents health.

A written response on an identified date in January, 2019, responded to the complainants concerns and outlined a summary of events, documentation review, and follow-up required by the home.

Review of the investigation notes included an email dated January, 2019, in which the written complaint and response were submitted to the Director. Interview with the Administrator confirmed that the written complaint and response was forwarded to the MOHLTC, but the allegation of abuse from the family of resident #001 was not reported immediately to the Director. [s. 24. (1)]

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 person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may have occur, immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #7: 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, required under section 8 to 16 of the Act, including assessments, reassessments, interventions and the residents responses to interventions were documented.

In accordance with Section 12 in the Act, the home shall ensure that there was an organized program of medical services for the home.

A) A review of a complaint intake submitted in October 2018, identified concerns related to consent for a treatment given to resident #010.

i) Consultation notes dated September, 2018, identified that residents #010, #012, and #013 received a treatment from an external physician. Review of the plans of care did not include the documented assessment of the residents related to the treatment, an order for the administration, dosage or location of administration until October, 2018, when the consultation notes were faxed to the home.

ii) Interview with RPN #143 confirmed that resident #010 and others, were assessed and administered a treatment on an identified date in September, 2018; however, the information was not documented in the residents' plan of care.

Interview with the DOC, who was not working in the home at the time that the treatments were administered, confirmed that it was the expectation that assessments, interventions, and reassessments, related to the treatment for residents, were documented. [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, required under section 8 to 16 of the Act, including assessments, reassessments, interventions and the residents responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) The plans of care for residents #024 and #029 identified that the residents required assistance of staff for bathing. Review of the Bath Schedule for identified home areas confirmed that residents #024 and #029 were scheduled to receive a bath on identified dates in June, 2019. Review of the bathing records did not include documentation to support that the residents received their bath on the identified dates in June, 2019, or that the scheduled baths were made up. A missed bath tracking form identified that both residents had missed a bath. The reason documented for the missed bath was "no bath nurse". Interview with PSW #104 and #219 confirmed that residents did not receive their baths as scheduled, as the home area was working less than the requirement complement for PSW staff.

Interview with the Employee Services Coordinator #107 confirmed that the home was not working at their full complement the identified dates in June, 2019, and that they did not receive the missed bath tracking forms from these dates, to ensure extra staff was scheduled to make up the missed bath.

Interview with resident #024 confirmed that they had missed two scheduled baths in June 2019, and they were not made up. [s. 33. (1)]

2. B) The plans of care for residents #027 and #028 identified that they required the assistance of staff with bathing. Review of bathing documentation identified that the residents did not receive their scheduled baths on identified dates in May and June, 2019, and there was no documentation to support that the bath was given at a different time. Interview with PSW #104 confirmed that on an identified date in June, 2019, PSW staff were working less than their required complement for PSW staff, and therefore, resident #027 did not receive their bath. Interview with PSW staff #216 confirmed that on the identified date in June, 2019, residents #027 and #028 did not receive their scheduled baths.

Interview with Employee Services Coordinator #107 confirmed that they did not receive a missed bath tracking form for identified dates in May or June, 2019, and therefore the staffing schedule was not adjusted to ensure the baths were made up. [s. 33. (1)]

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 was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in a medication cart that was secured and locked.

The home's policy "Medication Administration-IIA01, revised July 12, 2018", stated "during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse".

On an identified date in June, 2019, at 1155 hours, the medication cart for an identified home area, was observed to be unlocked while it was unattended outside of the dining room. RPN #105 was observed inside the dining room, giving medication to a resident with their back turned away from the medication cart. RPN #105 indicated that the medication cart should have been locked when they left it unattended.

During an interview with the DOC, it was identified that it was an expectation for medication carts to be locked when left unattended.

The home failed to ensure that drugs were stored in a medication cart that was secured and locked. [s. 129. (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 drugs are stored in a medication cart that is secured and locked, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports.

Section 24 of the Act requires the licensee to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019. 2007,

Review of the home's policy Abuse - Prevention, Elimination and Reporting Policy, effective May 2019, included a section titled "Mandatory Reporting to the MOHLTC" stated that the Ministry was to be notified immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could have potentially be detrimental to the resident's health and well being.

Interview with the DOC confirmed that the home's Abuse-Prevention, Elimination and Reporting Policy, effective May 2019, was the home's most current version of the policy and that it did not reflect all of the information in Section 24 of the Act, as required. The policy did not include all incidents outlined under section 24 of the Act, required to make mandatory reports. [s. 20. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was dressed appropriately, suitable to the time of day and in keeping with his or her preferences.

The plan of care for resident #002 identified that the resident required extensive assistance with dressing and directed staff to ensure the clothing was clean and appropriate.

i) In May, 2019, at 1130 hours, the resident was observed in their sleepwear. Interview with RPN #211 confirmed that the resident was waiting for their scheduled bath. Review of resident council minutes dated May, 2019, listed concerns that they found a resident in their sleepwear and was offered a bath right before lunch.
ii) On an identified date in June, 2019, from 0930 hours, the resident was observed in their sleepwear, until 1130 hours, at which time they were assisted with bathing.
iii) Interview with the family of the resident on the same date, confirmed that they were the resident's SDM and did not feel that the resident's dress was appropriate on the identified dates in May and June, 2019, when they were left in their sleepwear until their scheduled bath.
iv) Interview with the DOC confirmed that residents should not be left in their sleepwear because it was their bath day. In addition, the DOC stated that they were unaware of the SDM's concerns about resident #002's inappropriate dress; however, would ensure that the resident was dressed appropriately, according to the SDM's preferences on the resident's bath day. [s. 40.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was taking any drug or combination of drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug.

Review of the clinical record for resident #013 identified a consultation note dated in September, 2019, documenting that resident #013 received a medical treatment and would be reassessed in a few weeks. Review of the plan of care did not include a reassessment of the resident after the treatment. Interview with the Physiotherapist (PT) confirmed that in late October 2018, they were asked to assess residents who received the treatment. Interview with the Administrator confirmed that the PT reassessed residents following the treatment. Interview with PT confirmed that they were unaware that resident #013 had received the treatment in September 2018, and therefore, the resident was not evaluated. [s. 134. (a)]

Issued on this 19th day of July, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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) :	CAROL POLCZ (156), CYNTHIA DITOMASSO (528), EMMY HARTMANN (748), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2019_695156_0002
Log No. / No de registre :	027240-18, 027542-18, 028981-18, 032042-18, 032200-18, 000979-19, 001854-19, 001856-19, 001857-19, 001858-19, 001860-19, 001861-19, 002297-19, 002298-19, 002299-19, 003675-19, 009120-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 15, 2019
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 :	Sandy Hall

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Ministère de la Santé et des Soins de longue durée

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

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

The licensee must be compliant with s.6 (5) of the LTCHA.
Specifically the licensee must:

1. Ensure resident #001 is provided with the opportunity to participate fully in decisions and document the resident's participation, related to:

i. accessing their Personal Health Information, including but not limited to, staff members names who have provided care to the resident
ii. verbalized preferences at ongoing meetings and care conferences, so that the resident is comfortable discussing concerns
iii. any changes in relation to completing a specific activity
iv. any documentation in the plan of care related to incidents that place the resident or co-residents at risk
v. and at any other time when the resident expresses any concerns related to current plan of care

2. Ensure that resident #013 and their substitute decision maker (SDM) is provided the opportunity to fully participate in decision related to consent to medical treatments, and consent is documented.

3. Ensure that resident #002 and their SDM is provided the opportunity to fully participate in the plan of care in all areas including bathing.

4. Ensure that resident #044 and their SDM is provided the opportunity to fully participate in the plan of care in all areas including during any future outbreak situation affecting the resident.

Grounds / Motifs :

1. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

1. Review of a complaint intake from January 2019, outlined concerns of resident #001 not being notified of changes in their plan of care.

A) On an identified date in January, 2019, as a result of an incident where resident #001 placed a co-resident's safety at risk, an intervention was put in

place, which was to be re-evaluated in one month's time and as needed.

Interview with the Administrator and DOC on an identified date in May, 2019, they stated that they had seen an improvement in the residents civility with co-residents.

In February, 2019, the resident and their SDM met with the Administrator and DOC for a re-evaluation of the intervention. Review of meeting notes taken by the DOC, identified that both the resident and their SDM indicated that they wanted the intervention to stop and that it was not common ground. Interview with the Administrator confirmed that at the re-evaluation meeting, despite the resident and SDM's statements, no changes were made to the intervention and it remained in place after that meeting. Interview with three staff in the home, who requested to be anonymous, confirmed that the resident had a reaction with the intervention in place. Interview with the resident, throughout the course of the inspection, confirmed that they had concerns with the intervention in place.

Resident #001 was not included in the development and implementation of their plan of care related to the re-evaluation of their intervention in February, 2019.

B) Review of the plan of care for resident #001 identified that the resident required the assistance of staff for bathing and had known preferences.
i) Review of the bathing schedule for April 2019, identified that the resident was scheduled on an identified bathing shift twice a week. Interview with resident #001, staff #145 and #142 confirmed that the resident usually had regular staff assist them with bathing and that the resident was not included in the changes made to the bathing schedule in April 2019, which upset the resident.
ii) A progress note dated on an identified date in May, 2019, documented the resident preferred to have a bath at an identified time and did not want agency staff to assist them with bathing.
iii) Interview with the DOC confirmed that in April 2019, a new bathing schedule was created to assist with the home ensuring that all residents were bathed. The DOC stated that they were unaware of the change to the resident #001's bathing routine when the new schedule was created. Interview with the ADOC confirmed that after the changes in the resident's bathing schedule, they met with the resident on an identified date in May, 2019, and updated the plan of care and bathing schedule to reflect the resident's preferences for bathing.

The resident was not provided an opportunity to participate fully in changes in their plan of care, related to bathing, until after the changes had been made.

C) Review of the plan of care for resident #001 included a progress note from January 2016, which documented that the resident stated they could not complete an activity under identified circumstances. A physician order from April, 2016, directed staff to allow the resident to complete an activity. Interview with staff #142 confirmed supplies would be left with the resident to complete the activity.

i) A progress note dated in March, 2019, documented changes to the resident's care needs including, no longer providing supplies for the resident to complete the activity.
ii) Interview with ADOC #200 confirmed that as a result of unsafe practices, changes to the resident's orders were implemented immediately and the resident was notified of the changes.
iii) On an identified date in March, 2019, family of the resident expressed concerns, on behalf of the resident, to the Administrator in an email related to the changes in practices.
iv) On an identified date in April, 2019, a new physician order was written to leave the supplies with the resident to complete the activity but to return in five to ten minutes to ensure safe completion. A progress note dated April, 2019, confirmed that the resident was happy with the new physician order.
v) Interview with ADOC #200 confirmed that the unsafe practices were identified on a March, 2019 evening and therefore, the changes to the practices were implemented immediately. The ADOC also confirmed it wasn't until the following week that the resident was included in the decision making. Interview with staff #142 and the physician confirmed that the resident was upset that orders were abruptly changed on an identified date in March, 2019, and that the resident was not included in the development in the plan of care until after changes were made.

The resident was not included in the implementation of their plan of care related to changes in their care.

D) In January, 2019, as a result of an incident where resident #001 placed a co-

resident's safety at risk, resident #001 had interventions put in place. The interventions included but was not limited to measures to prevent a re-occurrence. The interventions included that any further incident would result in the immediate termination of an identified personal item while the incident was under investigation. A different item will be reinstated as well as a care provider for four hours a day

i) On the morning of an identified date in May, 2019, at approximately 1045 hours, the resident approached LTC Home Inspector #528 to notify them of an incident that occurred where they had contact with an identified staff member. The resident referred to a second staff member who witnessed the incident, staff #141. Interview with staff #141 confirmed that the incident appeared accidental.
ii) As a result of the incident, the police were called to the home to conduct an investigation. Approximately two hours after the incident, the Administrator, confirmed that they had called the police and had indicated that they had not spoken to the resident but would be doing so later that day.
iii) Subsequently, the resident had indicated that the management had not spoken to them on the day of the incident other than written correspondence on the evening of an identified date in May, 2019, requesting a meeting for an identified date in May, 2019, to discuss the event. The resident indicated that after the police were called, they were unsure of the home's actions. They expressed concern due to the intervention in place The resident stated, which was confirmed by progress notes, that they spent a specific period of time in a position/location with specific care provided by staff as needed.
iv) In a follow up interview with the Administrator on an identified date in May, 2019, they indicated that they had gone down to see the resident at the end of the day on an identified date in May, 2019, but the resident was not available for an interview and confirmed no one from the home had spoken to the resident about the incident, other than the police officer. They also confirmed that the manager on call was not notified that the resident had concerns. Interview with the physician on an identified date in May, 2019, identified they were concerned that the home had not spoken to the resident resulting in the resident's positioning/location for an identified period of time.

The resident was not included in the development and implementation of their plan of care when an incident occurred.

E) Review of the plan of care for resident #001 identified that they had a potential for specific responsive behaviours.

i) During the course of the inspection, resident #001 had identified a request related to their care conference in January, 2019.
ii) Interview with two identified staff members confirmed that at the care conference, the request was not honoured. Interview with the identified staff members confirmed the request for the preference at the care conference.
iii) Interview with the identified staff reported that they were unaware of the request related to the conference in January, 2019. In addition, they stated that the resident and SDM were upset at the conference.
iv) Interview with three staff in the home confirmed that they were aware of the resident's preference prior to the care conference in January, 2019.
v) Interview with ADOC #200, who was not working in the home at the time of the care conference, confirmed that if any resident made the specific request, the request would be respected. ADOC #200 also indicated that there had been circumstances where other actions were taken to meet an identified need.

The resident was not included in the development of the plan of care related to their care conference in January, 2019.

F) Review of a complaint submitted in October 2018, identified care concerns related to resident #001. In a follow-up conversation with the complainant in March 2019, they outlined additional concerns related to the resident not being provided their full plan of care.

i) The homes policy Access to Health Records/Copies of Heath Records/Release of Information, dated July 2016, indicated that the resident was entitled to copies of their health and medication records, with documented consent, APANS approval; and the suggested fee to be charged would be $0.15 per copy.
ii) Review of email correspondence from the complainant to the Administrator, confirmed that in January 2019, the complainant indicated that the resident would like a copy of their chart. On an identified date in January, 2019, the Administrator informed the complainant of the process the resident was to follow to request a copy of their medical record, noting residents and staff names would be redacted, resulting in an administrative fee.

iii) On an unidentified date, resident #001 requested a copy of their medical records including progress notes. Interview with the resident during the course of the interview, stated that the home removed all staff names from their medical record and was charged greater than $100.00 for the copy. Email correspondence dated March, 2019, from the Administrator, confirmed that the home had redacted the names of persons completing the charting, as directed by corporate office, and was reflected in the fee.
iv) Interview with the DOC on an identified date in May, 2019, confirmed that they had redacted the staff names from the resident's medical record as directed by the licensee; and then charged the resident for their time. Interview confirmed that the resident and family were upset with the redaction and requested the full record, which the home then supplied after approval from their corporate office.
v) The home was unable to provide a receipt for the purchase of; however, the DOC confirmed that the resident was charged more than the suggested amount in the policy for copies if this health care record because of the time it took to complete the task.
vi) On an identified date in March, 2019, after the resident and family expressed concerns to the home, a copy of the chart without the redaction was provided to the resident, the resident confirmed they paid an identified amount for the chart.

The resident was not included in the development and implementation of their plan of care when they were not provided full access to their health record, including staff names who provided care to the resident. [s. 6. (5)]

2. The plan of care for resident #002 identified that they required assistance with bathing.

i) On an identified date in June, 2019, the SDM for resident #002 stated that they were not consulted prior to the changes made to the bathing schedule in April 2019, and that the resident's bathing times had changed.

ii) Interview with the DOC, confirmed that changes to the home areas bathing schedule were based off the previous schedule; however, changes did occur to some of the scheduled baths. Interview with ADOC #200 and the DOC confirmed that residents and families were consulted after the changes were made.

The SDM for resident #002 was not provided the opportunity to participate fully in the development of the plan of care, related to the bathing schedule. [s. 6. (5)]

3. Review of a complaint intake submitted in October 2018, identified concerns related to consent for treatment given to resident #010.

A) Review of the plan of care for resident #010, identified that the resident had a cognitive status. A progress note dated in September, 2018, documented consent was given by the SDM for an identified assessment. Review of a consultation note dated September, 2018, identified that the resident received a treatment from an external physician. A complaint response letter dated October, 2018, confirmed that consent was obtained for assessment only and not obtained for the treatment. Interview with RPN #143 confirmed that consent was not obtained for the treatment administered in September 2018.

B) Review of the plan of care for resident #013 identified that the resident had a cognitive status. Review of a progress note on an identified date in September, 2018, included documentation that consent was obtained from the resident's SDM for an identified assessment. Review of a consultation note dated September, 2019, identified that the resident received an identified treatment. Interview with RPN #143 confirmed that consent was not obtained related to the treatment administered in September 2018.

LTC Home Inspector #130 interviewed the Administrator, at which time, the Administrator confirmed that consent was not obtained for approximately ten residents related to treatments given in September 2018. [s. 6. (5)]

4. On an identified date in March, 2019, resident #044 experienced a change in condition related to their overall health. The resident presented with identified symptoms within an eight-hour period. The condition could not be linked to any medication use or dietary issues. The resident was seen by a physician and received medication later in the evening. The SDM was notified on the same date that medication was being administered and that the resident had an unexplained symptom.

At the same time, the home was officially in an outbreak. The outbreak included all residents who had two or more identified symptoms within a 24-hour period.

The resident was therefore placed into isolation (confined to their room) beginning on an identified date in March, 2019. The resident's SDM reported that they were not informed that the resident was in isolation for outbreak symptoms until another identified date in March, 2019.

A review of the resident's clinical records did not include any notes to indicate that the SDM was informed about the resident's change in condition related to their health. Interviews with registered staff #142 and #221, revealed that although they spoke to the SDM on a daily basis to update them about the resident's condition, no one informed the SDM that the resident was also in isolation due to outbreak symptoms. The SDM therefore was not given an opportunity to discuss what the registered staff were doing for the resident and whether or not the SDM agreed with the course of action. (120) [s. 6. (5)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 2 as it related to a pattern. The home had a level 3 history of on-going non-compliance with this subsection of the Act that included:

-Voluntary Plan of Correction (VPC) issued in January 15, 2019 (2018_695156_0006) (528)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_556168_0011, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s.6 (10) of the LTCHA.
Specifically the licensee must:

1. Review and revise the plan of care for resident #041 and any other resident when their care needs change or care set out in the plan is no longer necessary.

2. Develop, implement and document an auditing mechanism, at times and frequencies determined by the licensee, to ensure that when a resident has a change in care needs, that they are reassessed and their plans of care revised to reflect those changes. Audit results are to be maintained and provided to Inspector(s) on request at the time of the follow-up inspection. This was previously ordered on January 24, 2019 (2018_556168_011) with a compliance due date of June 3, 1019, however, was only completed for falls by the home.

Grounds / Motifs :

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

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

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and any other time when, the resident's care need changed or care set out in the plan was no longer necessary.

Resident #041 was identified at risk for falls. The resident sustained a fall in June, 2019 and sustained an injury. The resident was given medication. The following day, the progress notes indicated a treatment was applied. The treatment was ordered on an identified date in June, 2019, however, a review of the care plan did not include the application of the treatment. The resident's plan of care was not reviewed and revised when the resident's care needs had changed in relation to the application of the treatment as confirmed with the RAI Coordinator. [s. 6. (10) (b)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 1 as it was isolated. The home had a level 4 history of on-going non-compliance with this subsection of the Act that included:

-Compliance Order (CO) issued January 24, 2019 (2018_556168_011) with a compliance due date of June 3, 1019;
-CO issued May 25, 2017 (2017_556168_0006) with a compliance due date of July 31, 2017 and complied on December 28, 2017;
-VPC issued May 27, 2016 (2016_343585_0007) (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2019

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

Ministère 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 : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The plan must include but is not limited to the following:
1. A detailed account of staff recruitment and retention strategies including time frames.
2. Written strategies that will be put in place to ensure coverage of vacation relief and sick or absent calls for regular RNs. Include who will be responsible for implementing the strategies/plan.

Please submit the written plan for achieving compliance for, 2019_695156_0002 to Carol Polcz, LTC Homes Inspector, MOHLTC, by email to HamiltonSAO.moh@ontario.ca by July 29, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Park Lane Terrace is a long-term care home with a licensed capacity of 132 beds with approximately 24 to 30 residents in each of the five home areas.

The master daily rosters were provided for five weekends from specified dates in May to June, 2019, by the Employee Services Coordinator on request.

A review of the daily rosters for the weekend shifts (15) indicated that over the identified time period there were nine occasions where an agency RN staff was on duty and there was not a member of the regular RN nursing staff of the home on duty and present in the home at all times.

Nine out of 15 shifts (60%) did not have a member of the regular RN nursing staff of the home on duty and present in the home at all times as confirmed with the Employee Services Coordinator. [s. 8. (3)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 2 as it related to a pattern. The home had a level 3 history of on-going non-compliance with this subsection of the Act that included:

-Compliance Order (CO) issued February 13, 2018 (2017_689586_0013) Complied February 19, 2019;
-CO issued August 15, 2017 (2017_556168_0026) (156)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2019

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

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 : 004

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

Linked to Existing Order / Lien vers ordre existant: 2018_695156_0006, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with s. 76 (2) of the LTCHA.

Specifically, the licensee must:
1. Ensure Agency PSW staff #112, #114, #119, #200, #203, #205, #120 and all other agency staff working in the home receive the training on areas identified in s. 76 (2) of the LTCHA as well as SALT training as per the home's orientation training package before working in the home.
2. Ensure the training records of Agency PSW staff #118, #121, #116, #131, #122, #113, #125, #123, #133, and #206 as well as Agency registered staff #128, #117, #115, #124, #127, and #126, are maintained in the home and provided to the Inspector(s) during the follow-up inspection.
3. Ensure the identified employee or any other new staff receive the training on all areas identified in s. 76 (2) of the LTCHA before working in the home.
4. Ensure the training records of staff and all agency staff working in the home will be maintained in the home.

Grounds / Motifs :

1. 1. The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

1. The Administrator reported that the process for agency staff was to come into the home one hour prior to their shift and to complete the orientation package and the Safe Assessment Lift Transfer (SALT) training prior to their shift. The Administrator provided a copy of orientation package to the inspector.

The following agency staff worked in the home since the compliance due date of April 15, 2019, from the compliance order issued during the Resident Quality Inspection (RQI) 2018_695156_0006 and did not receive the required

orientation training as noted above prior to working their first shift as confirmed with the Administrator:

a) Agency PSW staff #112 worked four shifts in April, 2019, as confirmed with the Employee Service Coordinator. The staff did not receive the required orientation training until after the identified shifts as reported by the Administrator.

b) Agency PSW staff #114 worked two shifts in total in April and May, 2019, as confirmed with the Employee Service Coordinator. The home was unable to produce any training records as reported by the Administrator.

c) Agency PSW staff #119 worked five shifts in total in April and May, 2019, as confirmed with the Employee Service Coordinator. The staff did not receive the required training until after the identified shifts as reported by the Administrator.

d) Agency PSW #200 worked a shift in April, 2019 however, the home was unable to produce any orientation training as reported by the Administrator.

e) Agency PSW staff #203 worked a shift in April, 2019 however, the home was unable to produce any orientation training as reported by the Administrator.

f) Agency PSW staff #205 worked a shift in April, 2019 however, the home was unable to produce any orientation training as reported by the Administrator.

g) Agency PSW #120 did not have SALT training prior to working their first shift in April, 2019 and had not completed training as of an identified date in June, 2019, as confirmed by the Employee Service Coordinator. The staff worked five additional shifts, in total, in April and May 2019 as confirmed with the Employee Service Coordinator. The staff received the orientation training package on an identified date in April, 2019 however, the training record was not maintained in the home as confirmed with the Administrator.

2. The Administrator reported that the home currently only uses an identified agency. The regional owner of this agency was contacted and reported that they provide their staff with an online training portal that they must complete prior to working any facility as agency staff. The training portal was reviewed

and did not contain home specific policies.
The Administrator provided a copy of the LTC home's orientation package provided to agency staff to complete prior to the completion of their first shift. The package did not contain the home's policy to minimize the restraining of residents; infection prevention and control; emergency and evacuation procedures as confirmed with the Administrator.

3. An identified employee began their employment on an identified date in April, 2019, and completed their first shift approximately one week later as confirmed with the DOC. The employee completed the required training by the time of their first shift with the exception of infection prevention and control as confirmed with the Administrator.

4. The home was previously ordered during RQI inspection 2018_695156_0006 to maintain a record of all agency staff training. As confirmed with the Administrator, the home did not have any orientation training records for the following agency staff:

a) Agency RN #128 received orientation training in December, 2018. The staff worked in May, 2019, as confirmed with the Employee Service Coordinator, however, the orientation training record was not maintained in the home as confirmed with the Administrator.

b) Agency RPN #117 received orientation training in December, 2018. The staff worked in April, 2019, as confirmed with the Employee Service Coordinator, however, the orientation training record was not maintained in the home as confirmed with the Administrator.

c) Agency RPN #115 received orientation training in January, 2019. The staff worked five shifts in total in April and May, 2019 as confirmed with the Employee Service Coordinator. The Administrator reported that the orientation training was not completed until completion of their second shift in April, 2019, and there was no record of the completion of the SALT training.

d) Agency PSW #118 received orientation training in January, 2019. The staff worked ten additional shifts in total in April and May, 2019, as confirmed with the Employee Service Coordinator. The orientation training record was not

maintained in the home as confirmed with the Administrator.

e) Agency PSW #121 received orientation training in February, 2019. The staff worked seven shifts in total in February, April and May, 2019 as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

f) Agency PSW #116 received orientation training in February, 2019. The staff worked five shifts in total in February, April and May, 2019, as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

g) Agency PSW #131 received orientation training in February, 2019. The staff worked two shifts in total in February and April, 2019, as confirmed with the Employee Service Coordinator, however, the orientation training record was not maintained in the home as confirmed with the Administrator.

h) Agency RPN #124 received orientation training in February, 2019. The staff worked four shifts in total in February, April and May, 2019 as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

i) Agency RPN #127 received orientation training in February, 2019. The staff worked five shifts in total in February, April and May, 2019, as confirmed with the Employee Service Coordinator. The Administrator reported that the staff did not complete the SALT or orientation training package until an identified date in May, 2019.

j) Agency PSW #122 received orientation training in March, 2019. The staff worked five shifts in total in March, April and May, 2019, as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

k) Agency RN #126 received orientation training in March, 2019. The staff worked three shifts in total in March and May, 2019 however, the home did not receive the record of the required training until an identified date after the shifts in May, 2019, as reported by the Administrator.

l) Agency PSW #113 received orientation training in March, 2019. The staff worked seven shifts in total in March, April and May, 2019, as confirmed with the Employee Service Coordinator. The home did not receive the record of the required training until identified dates in May, 2019, as reported by the Administrator.

m) Agency PSW #125 received orientation training in April, 2019. The staff worked six shifts in total in April and May, 2019, as confirmed with the Employee Services Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

n) Agency PSW #123 received orientation training in April, 2019. The staff worked two shifts in total in April and May, 2019, as confirmed with the Employee Services Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

o) Agency PSW #133 received orientation training in November, 2018. The staff worked three shifts in total in November, 2018, April and May, 2019, as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator.

p) Agency PSW #206 received orientation training in August, 2018. The staff worked four shifts in total in August, 2018, April and May, 2019 as confirmed with the Employee Service Coordinator. The orientation training record was not maintained in the home as confirmed with the Administrator. [s. 76. (2)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 2 as it related to a pattern. The home had a level 3 history of on-going non-compliance with this subsection of the Act that included:

-Written Notification (WN) issued January 24, 2019 (2018_556168_0011) This area of non compliance, was identified as a Compliance Order (CO) (2018_695156_0006) with a compliance due date of April 15, 2019;
-Compliance Order (CO) issued January 15, 2019 (2018_695156_0006);
-Voluntary Plan of Correction (VPC) issued May 24, 2017 (2016_556168_0030)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 07, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 005

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

Linked to Existing Order / Lien vers ordre existant: 2018_556168_0011, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8 (1).
Specifically, the licensee must:

1. Ensure that, should residents #032, #038, #040 and #041, or any other resident, sustain a fall, they are assessed and provided care as appropriate according to the licensee's policies in their falls prevention and management program to reduce the incidence of falls and the risk of injury, specifically the policies:
a) Post Fall Algorithm 5.2 and
b) Head Injury Routine 6.2 revised May 2019
2. Continue with the previously ordered January 24, 2019 (2018_556168_0011) auditing process to ensure that all residents who sustain a fall are assessed as required based on the falls policies. Document any follow up action taken when appropriate. The audits shall be completed at times and frequencies determined by the licensee and made available to the Inspector(s) at the time of the follow-up inspection.
3. Ensure that, should resident #038 or any other resident, receive a medication, that the administration of the medication is documented as appropriate according to the licensee's policies in their medication administration program, specifically the policy IIA01 dated July, 2018.

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

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

Grounds / Motifs :

1. 1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services. Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

1. In accordance with O. Reg 79/10, s. 48 (1) 1 and in reference to O. Reg s. 49 (2), the licensee is required to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the licensee's Post Fall Algorithm 5.2 which was part of the licensee's Falls Prevention Policy last revised May 2018, and completion of the Head Injury Routine (HIR) last revised May 2019 which was part of the policy.

The Post Fall Algorithm identified that when a resident sustained a fall staff were to: communicate fall risk to other care staff; place a falling star logo at bedside/wheelchair/walker.

The policy identified that a HIR would be initiated for all resident falls that were not witnessed and for witnessed resident falls that included the possibility of a head injury.

A) Resident #032 was identified at risk for falls. According to the clinical record, the resident sustained a fall in May, 2019.

i) Observation of the resident, in June, 2019, and their room verified that the falling star logo was not in place for the resident as confirmed by PSW's #151 and #103.

ii) A review of the clinical record, for the fall of the identified date in May, 2019, did not include a completion of the HIR as required. Documentation of the HIR was completed on identified scheduled times; however, not fully completed. In June, 2019, registered staff #105, following a review of the clinical record verified that the HIR was not documented as completed at the frequency required for the resident post fall.

B) Resident #038 was identified at risk for falls. The resident sustained a fall on an identified date in May, 2019, and sustained an injury.

i) A review of the clinical record, for the fall in May, 2019, did not include a completion of the HIR as required. Documentation of the HIR was only completed on two identified times. On an identified date in June, 2019, registered staff #142, following a review of the clinical record verified that the HIR was not documented as completed at the frequency required for the resident post fall.

ii) Observation of the resident, on an identified date in June, 2019, verified that the falling star logo was not in place for the resident as confirmed by registered staff #142 and PSW staff #144.

C) Resident #040 was identified at risk for falls. The resident sustained a fall on an identified date in June, 2019 and sustained an injury.

A review of the clinical record, for the fall of the identified date in June, 2019, did not include completion of the Head Injury Routine (HIR) as required. Documentation of the HIR was completed on identified scheduled times; however, not fully completed. On an identified date in June, 2019, interview with the RAI Coordinator, following a review of the clinical record verified that the HIR was not documented as completed at the frequency required for the resident post fall.

D) Resident #041 was identified at risk for falls. The resident sustained a fall on an identified date in June, 2019 and sustained an injury.

A review of the clinical record, for the fall in June, 2019, did not include a completion of the Head Injury Routine (HIR) as required. Documentation of the HIR was completed on identified scheduled times; however, not fully completed. On an identified date in June, 2019, interview with the RAI Coordinator, following a review of the clinical record verified that the HIR was not documented as completed at the frequency required for the resident post fall.

2. In accordance with O. Reg. 79/10 s. 114 (2) the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, the home did not comply with the home policy "Medication Administration" IIA01 dated July, 2018, indicated under Documentation that when PRN medications are administered, the following documentation is provided on the electronic Medication Administration Record (eMAR): date and time of administration, dose, route of administration (if other than oral), and if applicable the injection site; complaints or symptoms for which the medication was given; results achieved from giving the dose and time results were noted; documentation of person recording administration and documentation of person recording effects, if different form the person administering the medication.

A) Resident #038 was identified at risk for falls. The resident sustained a fall on an identified date in May, 2019 and sustained an injury.

The clinical record including the eMAR and progress notes were reviewed. On an identified date in May 2019, progress notes indicated that PRN medication was administered to resident #038 as the resident complained of pain following the fall. Interview with registered staff #142 confirmed that the administration of the medication was not documented. [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 2 as it related to a

pattern. The home had a level 4 history of on-going non-compliance with this subsection of the Act that included:

-Compliance Order (CO) issued January 24, 2019 (2018_556168_0011) with a compliance due date of April 29, 2019;
-Voluntary Plan of Correction (VPC) issued January 15, 2019, (2018-695156-0006);
-VPC issued February 13, 2018, (2017-689596-0013);
-Written Notification (WN) issued September 7, 2016, (2016-210169-0011);
-WN issued September 7, 2016, (2016-210169-0012);
-VPC issued May 27, 2016, (2016-343585-0007) (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 006

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

Linked to Existing Order / Lien vers ordre existant: 2018_695156_0006, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 36.

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The plan must include but is not limited to the following:
1. A description of how the home will ensure that staff use safe transferring and positioning devices or techniques when assisting resident #011 and all other residents.
2. The dates for retraining for safe transferring and positioning for Agency PSW #121 and any other staff. A copy of the training records shall be maintained in the home.
3. A description of monitoring and prevention strategies including an auditing process to ensure that resident #011 and all other residents are safely transferred, positioned and not left unattended. Include who will be responsible for implementing the strategies/plan.

Please submit the written plan for achieving compliance for, 2019_695156_0002 to Carol Polcz, LTC Homes Inspector, MOHLTC, by email to HamiltonSAO.moh@ontario.ca by July 29, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

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

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted a CI report in May, 2019, reporting improper/incompetent treatment to a resident that resulted in harm or risk to a resident. On an identified date in May, 2019, resident #011 was receiving care from agency PSW #121. The resident was left unattended in an unsafe position by the PSW. When left unattended, the resident sustained a fall which resulted in injury. PSW #121 confirmed that they did not use safe transferring and positioning techniques when assisting resident #011 when they left the resident unattended in the position which resulted in the resident sustaining a fall.

It was noted that the staff did not have the required SALT training until an identified date in May, 2019, as confirmed with the Employee Service Coordinator. [s. 36.]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it was isolated. The home had a level 4 compliance history as there was on-going non-compliance with this subsection of the Act that included:

-Compliance Order (CO) issued January 15, 2019 (2018_695156_0006) with an amended compliance due date of May 1, 2019;
-CO issued May 25, 2017 (2017_556168_0006) with a compliance due date of June 30, 2017 and complied on December 28, 2017;
-CO issued May 27, 2016 (2016_343585_0007) with a compliance due date of July 16, 2016 and complied on August 26, 2016. (156)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

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