Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2016	2016_229213_0014	004562-16	Critical Incident System

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

Long-Term Care Home/Foyer de soins de longue durée

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

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

RHONDA KUKOLY (213), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 13, 14, 15, 20, 21, 2016

This inspection was completed related to two critical incidents:
Log #004562-16, critical incident #3047-000002-16 related to reported alleged abuse of a resident, and
Log #005961-16, critical incident #3047-000003-16 related to an alleged inappropriate transfer of a resident.

This inspection was completed concurrently while in the home completing two follow up inspections: log #00001219-16 and log #008403-16, as well as two complaint inspections: log #008504-16 and log #009805-16.

During the course of the inspection, the inspector(s) spoke with the President and Chief Operating Officer, the Administrator, the Acting Administrator, the Director of Care, the Acting Director of Care, the Geriatric Clinical Nurse Specialist, the Assistant Director of Care, a Registered Nurse, two Registered Practical Nurses, the Responsive Behaviour Program Personal Support Worker, two Personal Support Workers and two residents.

The Inspectors also reviewed health records, education records, internal investigation records, policies and procedures, other relevant documentation, and made observations.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may have resulted in responsive behaviours, and written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed to meet the needs of residents with responsive behaviours.

Record review of the health record for resident #002, critical incident #3407-000002-16, and the home's internal documentation, revealed resident #002 had cognitive impairment and exhibited a number responsive behaviours. There were no assessments related to these behaviours found in the health record and no strategies or interventions identified related to these behaviours found in the plan of care.

Staff interview with a Registered Practical Nurse (RPN) #111 confirmed that the resident is known to staff to have responsive behaviours. The RPN confirmed that there was no direction in the plan of care for staff related to these responsive behaviours. The RPN was not able to identify if this resident had been referred to the home's Responsive Behaviour Program for assessment.

Staff interview with the home's Responsive Behaviour Team Personal Support Worker (PSW) #132 confirmed that resident #002 had not been seen or assessed by the home's Responsive Behaviour Team.

Staff interview with the Geriatric Clinical Nurse Specialist (GCNS) #105 on April 15, 2016, confirmed that resident #002 is known to staff to have responsive behavoiurs and the resident had a specific history impacting the behaviour. The GCNS reported that she had learned this information while completing the internal investigation related to the critical incident, in interviewing staff, and in speaking with the family of resident #002.

The GCNS confirmed that these behaviours had not been identified or assessed, and that goals, triggers, strategies and interventions had not been developed or implemented related to these behaviours. She confirmed that there is a process in the home to refer residents with responsive behaviours to the home's internal Responsive Behaviour Program. The GCNS confirmed the home's expectation was that once responsive behaviours had been identified, resident #002 should have been referred to the Responsive Behaviour Program, assessed, goals and interventions developed and implemented, and the plan of care revised. The GCNS #105 confirmed that the home failed to meet the needs of resident #002 related to managing their responsive behaviours. [s. 53. (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 written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, and written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours., to be implemented voluntarily.

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Issued on this 12th day of May, 2016

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

Original report signed by the inspector.