Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Sep 13, 2016	2016_229213_0031	019031-16 019042-16	Complaint

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)

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): September 2, 2016

This inspection was completed related to:
Complaint Infolines #IL-45119-LO and IL-45273-LO regarding care concerns and, Critical incident #3047-000051-16 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Director of Recreation, a Physiotherapist, a Registered Nurse, a Registered Practical Nurse, the Behavioural Support and Restorative Care Personal Support Worker, four Personal Support Workers, three residents, and a family member.

The inspector also made numerous observations; and reviewed health records, policies and procedures, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Recreation and Social Activities
Responsive Behaviours

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of safety risks with respect to the resident.

Progress notes on an identified date indicated resident #001 had been found exhibiting a responsive behaviour that was a safety risk requiring treatment. Progress notes indicated that a Personal Support Worker indicated that this was an ongoing behaviour.

In an interview with the Administrator #101 on September 2, 2016, the Administrator said that this incident had occurred prior to her, as well as the current Director of Care, beginning working in the home. She shared that in a conversation with the substitute decision maker of resident #001 approximately four months after the incident, regarding the resident satisfaction survey, the resident's substitute decision maker advised her of the incident. The Administrator submitted a critical incident report to the Ministry of Health and Long Term Care at that time and completed an investigation. The Administrator shared that that the investigation revealed that staff had suspected that it was possible the resident was exhibiting this behaviour prior to the identified date, but had no evidence to support the suspicion conclusively.

The plan of care for resident #001 included the identified responsive behaviour and interventions; however, this intervention was initiated one month after the incident of resident #001 exhibiting this behaviour.

The home failed to complete an assessment and identify that resident #001 had an identified responsive behaviour in the plan of care when they became aware of this safety risk. [s. 26. (3) 19.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of safety risks with respect to the residents, to be implemented voluntarily.

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Issued on this 13th day of September, 2016

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

Original report signed by the inspector.