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 # / No de registre	Type of Inspection / Genre d'inspection
Sep 22, 2017	2017_607523_0021	014699-17, 018683-17, 019033-17	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

ALI NASSER (523), ALISON FALKINGHAM (518), NANCY SINCLAIR (537)

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): August 17, 18, 21 and 22, 2017.

The following complaint inspections were completed during this inspection:
Log # 014699-17 / IL-51750-LO related to staffing shortages affecting resident care.
Log # 018683-17 / IL-52330-LO related to staffing shortages affecting resident care, allegations of abuse not investigated or reported.
Log # 019033-17 / IL-52409-LO related to lack of management support for staff.

During the course of the inspection, the inspector(s) spoke with the CEO/President, the Administrator, Director of Care, previous Assistant Director of Care, Resident Care Coordinator, Resident Assessment Instrument (RAI) Coordinator, Dietary Services Manager, one housekeeping staff, 10 registered staff members, 10 Personal Support Workers (PSW), two family members and 14 residents.

The inspector(s) also observed meal services, observed residents and resident staff interactions, reviewed clinical records for identified residents and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **2 VPC(s)**
- **5 CO(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse

and neglect of residents was complied with.

A. In an interview, a PSW said that on a certain date they witnessed a specific resident expressing an identified behaviour towards another resident while they were asleep. The PSW said that the resident had a history of this certain behaviours, the PSW intervened and moved the other resident to safety, then informed the RN about what they witnessed. The RN told the PSW that this behaviour was totally fine.

Clinical record review showed that one of the residents was cognitively impaired.

In an interview, the RN acknowledged that they were informed that the residents were expressing a certain behaviour. The RN told the PSW that this was ok. RN said "I have seen them expressing this behaviour before, I did not think that was a form of abuse". The RN was not able to define or describe a certain type of abuse, and they said the behaviour was not abuse as those residents did that frequently. RN then acknowledged that because the behaviour was done frequently that did not mean it was an ok behaviour.
The RN said that they were not aware that the resident had previous expression of this behaviour. They did not ask the other resident or their SDM if they were ok if a resident expressed this type of behaviour towards their resident.
The RN acknowledged that when they were informed by a PSW of allegations of suspected abuse, they did not immediately investigate or report those allegations.

A review of the home's policy Resident Non-Abuse, index: LP-C-25, revised March 2016, showed that:
Any employee who becomes aware of an alleged, suspected, or witnessed resident incident of abuse or neglect will report it immediately to the Administrator or, if unavailable to the most senior supervisor on shift at that time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Administrator immediately.
An immediate dignified and respectful investigation of the reported alleged, suspected or witnessed abuse will be initiated by the Administrator/designate.

In an interview, the Administrator acknowledged that the PSW informed the RN of allegations of resident to resident abuse. RN told PSW that this was ok.
The Administrator said that the expectation was for the staff to follow the procedure and immediately investigate and report any allegations of abuse.

B. In an interview, a RPN said that a specific resident's family member was told that the resident received inappropriate behaviour from another resident.
The RPN immediately checked on the residents and said that they considered this to be an allegation of abuse. The RPN then notified the RN who was the charge nurse on duty.

In an interview, the RN said that they were not aware of this incident, this incident was not reported to them.

In an interview, the DOC said the expectation was that the staff would report to their shift leader any allegation of abuse or neglect. The shift leader would be expected to ensure that the resident was out of immediate risk. Then they would be expected to notify the charge nurse, who would then contact a manager, either in the building or by the afterhours call list.
The DOC said that they were not aware of this incident. The DOC contacted the RCC, they were also not aware of this incident.

In an interview, the Administrator said that the expectation was for the staff to follow the procedure and immediately investigate and report any allegations of abuse.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern and this area of non-compliance was previously issued as a Written Notification on January 4, 2016, under Critical Incident inspection #2015_303563_0055. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with 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 has failed to ensure that when a person who had reasonable grounds to suspect that any abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

In an interview, a resident said that they witnessed a resident expressing a certain behaviour towards another resident.
The resident said "I wrote a letter and gave it to the ADOC, they took it from me but they did not talk to or ask me any questions about it".

In a telephone interview, the ADOC said that they left the home earlier in the month. They recalled taking a letter from the resident but it was related to personal concerns with a PSW and not related to abuse.
The ADOC said that they do not recall any allegations of abuse from the resident. ADOC said "all letters received were documented in the notes and I gave all the letters to the DOC or Administrator".

In a clinical record review, a progress note by the ADOC on a certain date showed that the resident requested to speak with the ADOC in regards to their concerns (observing residents, staff and their feelings). The resident handed ADOC two letters, one from PSW staff and one of the notes that the resident wrote.

A clinical record review showed no further notes from the ADOC about the letters.

In an interview, the Administrator said that they knew the ADOC received a letter of concerns from the resident and thought that it was addressed right away.
The Administrator was not able to find those letters.

A review of the Critical Incident System (CIS) showed there was no submission of those allegations of abuse to the Director.

The Administrator said that the expectation was for the ADOC to report allegation of abuse immediately to the Director.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern and this area of non-compliance was previously issued as a:
Written Notification and Compliance Order on March 08, 2016, under Resident Quality Inspection #2016_229213_0005, Compliance Order was complied with on April 26, 2016.

Written Notification and Compliance Order on January 4, 2016, under Complaint inspection #2015_303563_0054, Compliance Order was closed with link to inspection #2016_229213_0005.
Written Notification and Voluntary Plan of Correction on June 26, 2015, under Complaint inspection #2015_229213_0022.
Written Notification and Voluntary Plan of Correction on May 20, 2015, under Resident Quality Inspection #2015_416515_0013.
Written Notification on February 13, 2015, under Critical Incident inspection #2015_260521_0007. [s. 24. (1) 2.]

Additional Required Actions:

CO # - 002 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. 75. Screening measures

Findings/Faits saillants :

1. The licensee has failed to ensure that screening measures including criminal reference checks were conducted in accordance with the regulations before hiring staff and accepting volunteers.

A review of Complaint IL-52251-LO showed that staff have been hired in the home without a police check.

An employee file review of a certain number of staff showed that some had no police check completed with vulnerable sector screening.

In an interview, the DOC acknowledged that every staff needed to have a police check with vulnerable sector clearance before they work in the home with the residents. The DOC said that the home sometimes hired staff and completed orientation before they had the police check results as it takes time for the police report to come back.

The Inspector completed a review of the employee files with the DOC. The DOC verified the findings of the Inspector's employee file review.

The DOC did not know how staff started working with no criminal checks completed, and said that the expectation was for staff not to work with residents unless all of their employment requirements were done.

In an interview, the Administrator said that the expectation was for all the employees hired by the home to have a criminal record check completed with vulnerable sector screening before being hired by the home.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern and similar area to this non-compliance was previously issued as a Written Notification and Voluntary Plan of Correction on March 3, 2015, under Complaint inspection #2015_260521_0004. [s. 75.]

Additional Required Actions:

CO # - 003 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The Inspector was informed during the inspection that a RN was directed by a management team member to allow an agency RPN to administer medications under the RN's log in access. The RPN administered medications and signed as if the RN completed the medication pass. The RPN made two medication errors that would appear under the RN's name.

A review of a medication incident report completed by the home on a specific date showed the following in the manager's response "RPN's first time at ECV (Earl's Court Village) from an agency. RPN used RN's access code as RPN did not have a Login to Point Click Care (PCC) or the Electronic Medication Administration Record (EMAR). RN got instructions from management".

In an interview, the RPN said that they worked in the home on a certain date for their first shift, they got four hours orientation on the same day before their shift started.
The RPN said that they did not have their own access to the EMAR or PCC and the RN signed them into the EMAR to administer medication under their log in.

The RPN acknowledged that they administered the medications under the RN's log in and that on EMARs it was the RN's signature that was showing as the nurse who administered the medications.

In an interview the RN said that on that date the agency RPN had no log in access to PCC or EMARs.
The RN said that the CEO/President was in the building and they advised them to log in and permit the RPN to sign under their name when the medication was administered.

The RN acknowledged that the RPN made two medication errors on that shift and that those errors were logged under the RN's name.

A review of the home's policy Medication/Treatment Administration Records, index: NAM-G-90, effective date: January 2014, showed that when a Registered Staff administers medication/treatment, this person must initial MAR/TAR sheet under correct date and time of administration or assign their electronic initials with the electronic medication and treatment administration software.

In an interview, the Administrator acknowledged that the home's policy was not complied with and said that it was the home's expectations that nurses administer medications under their own log in. If the log in was not available then they would administer and sign on paper MARs.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated, this area of non-compliance was previously issued as a Written Notification and Voluntary Plan of Correction on March 8, 2016, under Resident Quality Inspection #2016_229213_0005.
Written Notification and Voluntary Plan of Correction on June 5, 2015, under Resident Quality Inspection #2015_416515_0013.
Written Notification and Voluntary Plan of Correction on February 25, 2015, under Complaint inspection #2015_259520_0003.
Written Notification on February 23, 2015, under Critical Incident inspection #2015_260521_0007.
Written Notification and Compliance Order on October 21, 2014, under Complaint inspection #2014_232112_0067. Compliance Order was complied with on December 19, 2014. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Multiple complaints received through the Ministry of Health and Long-Term Care ACTION Line related to staffing shortage impacting residents' care.

A. A review of the staff schedules with the Administrator showed that for a specific period of time the home worked short staffed. The Administrator said that they currently had one RN, four RPN and five PSW lines vacant.
The Administrator said that in a specific period of time several management staff had left the home, some of which were replaced, others were still in orientation and some were in

the process of recruitment, this added a lot of stress on managers and created a lot of mistakes in payroll and scheduling including the nursing department.
The Administrator said that the Dietary Services Manager (DSM) was feeling overwhelmed and unsupported especially after adding payroll and scheduling to their duties. DSM resigned and a new DSM had just started.
The Activity Manager also resigned for the same reasons, they did not feel supported and the work load was unmanageable.
The ADOC resigned and left the home early August, the DOC was on leave from August 4-28.
The Administrator said that they analyzed and tracked when the sick calls and shortages occurred most, they requested to over staff on those occasions to ensure proper staffing but this request was denied by the corporate office due to budget concerns.
The Administrator said that they also suggested hiring full time rather than part time or casuals, but also was denied by the corporate office due to budget reasons, as full time now require benefits and so on.

B. In an interview, a resident said an identified home area was always short of staff, the resident had to wait for everything. The resident said that they required assistance to go to the toilet. They were continent and they used to wait a long time for staff to respond to the call bell. They said that they soiled their pants with urine and stool because of the delay in response. A review of the call bell log for a certain period of time showed that the resident on multiple occasions waited from 13-36 minutes for staff to respond to the call bell.

C. In an interview, a resident said that the home was short staffed mostly on the weekends, and for all disciplines. The resident said that they were affected by staffing shortages as they require assistance to eat and to go to the toilet. On multiple occasions they had to wait an hour to be fed and an hour to be changed from a soiled brief. The resident expressed real stress and fear as this may result in skin breakdown and they did not want any sores as a result of that.
A review of the missing task report for a specific period of time showed that the resident had 42 missing tasks for routine toileting, bladder and bowel tasks.
The RAI Coordinator said in an interview that they were aware of the missing tasks that were not completed or signed for the residents due to shortage of staff. They said that they run those reports and give them to the DOC to follow up with staff and to the Administrator to address sufficient staffing.

D. In an interview, a resident's family member said that the resident required certain

assistance for toileting, and required assistance with feeding. The family member said that they came to the home every day to ensure the resident received the care they needed. The family member said that they rang the call bell for assistance and the average wait time was around 10 minutes, however when the staff responded to the call bell they would shut it off and say they will return with a partner to assist and this may take up to 30 minutes.
A review of the call bell log for a certain period of time showed that the resident on multiple occasions waited 10-26 minutes for staff to respond to call bell.

E. In an interview, a resident said that they were short of staff a lot, even when fully staffed they seemed too busy to handle the work. The resident said that they wore an incontinent product and were supposed to be toileted at a certain frequency. The resident said between the time they got up in the morning to the time they went to bed in the evening they would probably get toileted twice a day only. The resident said that they were usually soaked through with urine and this made them mad and embarrassed. The resident said that they had to change the product they used to a different type so it could hold more urine because the staff can not change them at the required frequency. The resident also said that residents, including themself, were not given baths twice a week.
A review of the resident plan of care showed that the resident was on a toileting routine at a certain frequency. A review of the task record for a certain period of time showed that the resident had 34 missing tasks for the toileting routine. A review of the task record for a certain period of time showed that the resident did not have two baths a week for the period of two weeks.
Observations on a certain date and time showed the resident was not toileted during this time. A PSW said that they were not able to toilet the resident as per their toileting routine due to staffing shortages.

F. Observations on a certain date and time showed a resident was in the common area using a specific restraint device. The resident was not approached, turned, repositioned and the restraint was not removed and reapplied and the resident was not toileted.
A review of the plan of care and the task list report for a certain period of time showed the following:
Restraint Check at specific times. This task was not signed 73 out of 315 times (23 percent).
Monitor-turning and repositioning at specific times. This task was not signed 48 out of 252 times (19 percent).
Restraint-removed for repositioning and reapplied at specific times. This task was not signed 34 out of 147 times (21 percent).

The resident received one bath a week for two weeks.
A PSW said in an interview that they were not able to provide care for the resident such as toileting, positioning, removing and reapplying restraint since the resident was put in the common area in the morning and staff would not be able to provide care until after lunch.

G. In an interview, a PSW said that they were not able to change and position a certain resident as required which caused skin break down. The resident did not receive two baths a week during a specific two week period of time.
In an interview, a RPN said that they completed a skin assessment on the resident on a certain date, the skin was intact. They reassessed the resident two days later and the resident had three areas of altered skin integrity.
A review of the resident's task list report showed that the resident was on a toileting program at specific times. On the dates between the assessments this task was not signed five out of 12 times (42 percent).
A review of the skin and wound assessment showed that the resident had new areas of concerns related to altered skin integrity.

H. Observations by inspectors throughout the inspection showed that at lunch time some residents waited 30-45 minutes to be served their drinks and lunch. Other residents waited 20-30 minutes to get their fruits or deserts.

I. In an interview, a PSW said that when they work short staffed they were not able to complete daily tasks like toileting, positioning, restraint safety checks and assisting residents to bed on time. They were not able to complete two baths a week for residents.

In an interview, a PSW said that they worked short staffed almost every day, especially on the weekends. When short staffed, residents were not receiving the proper care they needed like toileting, safety checks, restraint checks and positioning and staff were not able to complete all the care needed for the residents as per the plan of care.
The PSW said that in addition to previous examples, another resident did not receive two baths a week for a specific two week period of time. This was confirmed by a review of the task records.

In an interview, a PSW said that they worked short mostly on weekends. They were not able to complete baths for residents and two baths a week were not being done. Staff were not able to complete tasks such as safety checks, repositioning, toileting and

assisting residents in and out of bed on time.
The PSW said "there were residents that required assistance in feeding and it usually took us an hour and a half to finish meal service".

In an interview, a RPN said that they worked short staff mostly on the weekends.
When the home was short staffed, breakfast or lunch service and medication pass took at least an hour and a half to complete.
The RPN said that working short resulted in tasks such as positioning, toileting and restraint checks for residents not being done.

In an interview, the RN said that they worked short staffed and this put the residents at risk. Staff did not get the support that they needed to provide proper care to residents. PSWs were not able to complete tasks necessary for resident’s safety and were not able to complete resident care tasks because they were short staffed. Nurses were covering on two units which caused delays in providing care and administering medications.

In an interview, the RN said that they worked on a certain date and on that day they were short of nurses.
The RN called the RCC and the Administrator but no help was provided.
The CEO/President was in the building and told them to do what they could and finish on time.
The RN said that they covered two units on that day. They were delayed in providing treatment and medications within the one hour before or after scheduled times. The RN acknowledged that the medication pass took around three and a half hours to complete.
The RN said that management were informed that staffing shortages were impacting resident care. Staff were told to do what they could.

In an interview, a RPN said that they currently were doing the schedules. The RPN said that different hiring strategies were suggested to the corporate office to address the staffing shortages but those suggestions were declined due to budget concerns.
The RPN said that the Administration of the home were aware that the staff were not able to complete all residents' related tasks as a result of the staffing shortages.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern, this area of non-compliance was previously issued as a: Written Notification and Compliance Order on March 8, 2016, under Resident Quality Inspection #2016_229213_0005. Compliance Order was complied with on April 14, 2016.

Written Notification and Voluntary Plan of correction on December 24, 2014, under Complaint inspection #2014_303563_0061. [s. 31. (3)]

Additional Required Actions:

CO # - 005 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 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 an area or a medication cart that was secured and locked.

Observations on a certain date and time showed a medication cart in the hallway close to the medication room. The medication cart was unlocked and unattended in the hallway. Several residents were walking in the hallway near the medication cart. The RPN said that they forgot to lock the cart. They said that the expectation was to lock the cart when unattended.

Observations on a certain date and time showed a medication cart in the common area close to the dining room. The medication cart was unlocked and unattended. The RPN said that they forgot to lock the cart. They said that the expectation was to lock the cart when unattended.

Observations on a certain date and time showed a medication cart was in the common area by the dining room. The cart was unlocked and unattended. A RPN said that the cart did not lock all the time, this was a known problem and it was fixed before but now it seemed the problem was back.
The RPN demonstrated the locking mechanism for the inspector and it worked. The inspector asked if RPN reported the malfunction of the lock. The RPN said no.
The RPN said that the expectation was to keep the medication cart locked when unattended.

In an interview the Administrator said that staff tried to push the lock half way through when they leave the medication cart so they did not have to use the key to unlock it when they came back.
Administrator acknowledged that the medication cart was to be locked and secured when unattended.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated, this area of non-compliance was previously issued as a:
Written Notification and Voluntary Plan of Correction on March 8, 2016, under Resident Quality Inspection #2016_229213_0005.
Written Notification and Voluntary Plan of Correction on February 27, 2015, under Complaint inspection #2015_259520_0004. [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 were stored in an area or a medication cart that was secured and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector; O. Reg. 79/10, s. 213 (4).
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and O. Reg. 79/10, s. 213 (4).
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the DONPC had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

In an interview, the Administrator said that the DOC was on leave for a certain period of time for which the ADOC and the RN had covered that position during that time.
A review of the staffing schedule and payroll sheet showed that the RN covered the DOC for five shifts, two out of the five shifts had RN duties assigned as well.

In an interview, the ADOC said that they were assigned to cover for the DOC when they were away, the ADOC said that they did not have any supervisory or managerial experience to do this role. The ADOC said that they shared this with the Administration of the home but they were left alone with no support.

In an interview, the DOC acknowledged that the home did not have appropriate coverage for their role when they were away.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated, this area of non-compliance was not previously issued. [s. 213. (4)]

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 DONPC had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting, to be implemented voluntarily.

Issued on this 3rd day of October, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALI NASSER (523), ALISON FALKINGHAM (518), NANCY SINCLAIR (537)
Inspection No. / No de l'inspection :	2017_607523_0021
Log No. / No de registre :	014699-17, 018683-17, 019033-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 22, 2017
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Katie Villeneuve-Rector

To SHARON FARMS & ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with, specific but not limited to, when staff suspect or are informed of any witnessed or alleged abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

A. In an interview, a PSW said that on a certain date they witnessed a specific resident expressing an identified behaviour towards another resident while they were asleep.
The PSW said that the resident had a history of this certain behaviours, the PSW intervened and moved the other resident to safety, then informed the RN about what they witnessed. The RN told the PSW that this behaviour was totally fine.

Clinical record review showed that one of the residents was cognitively impaired.

In an interview, the RN acknowledged that they were informed that the residents were expressing a certain behaviour. The RN told the PSW that this was ok. RN said "I have seen them expressing this behaviour before, I did not think that was a form of abuse".
The RN was not able to define or describe a certain type of abuse, and they said the behaviour was not abuse as those residents did that frequently. RN then

acknowledged that because the behaviour was done frequently that did not mean it was an ok behaviour.
The RN said that they were not aware that the resident had previous expression of this behaviour. They did not ask the other resident or their SDM if they were ok if a resident expressed this type of behaviour towards their resident.
The RN acknowledged that when they were informed by a PSW of allegations of suspected abuse, they did not immediately investigate or report those allegations.

A review of the home's policy Resident Non-Abuse, index: LP-C-25, revised March 2016, showed that:
Any employee who becomes aware of an alleged, suspected, or witnessed resident incident of abuse or neglect will report it immediately to the Administrator or, if unavailable to the most senior supervisor on shift at that time.
The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Administrator immediately.
An immediate dignified and respectful investigation of the reported alleged, suspected or witnessed abuse will be initiated by the Administrator/designate.

In an interview, the Administrator acknowledged that the PSW informed the RN of allegations of resident to resident abuse. RN told PSW that this was ok.
The Administrator said that the expectation was for the staff to follow the procedure and immediately investigate and report any allegations of abuse.

B. In an interview, a RPN said that a specific resident's family member was told that the resident received inappropriate behaviour from another resident.
The RPN immediately checked on the residents and said that they considered this to be an allegation of abuse. The RPN then notified the RN who was the charge nurse on duty.

In an interview, the RN said that they were not aware of this incident, this incident was not reported to them.

In an interview, the DOC said the expectation was that the staff would report to their shift leader any allegation of abuse or neglect. The shift leader would be expected to ensure that the resident was out of immediate risk. Then they would be expected to notify the charge nurse, who would then contact a manager, either in the building or by the afterhours call list.

The DOC said that they were not aware of this incident. The DOC contacted the RCC, they were also not aware of this incident.

In an interview, the Administrator said that the expectation was for the staff to follow the procedure and immediately investigate and report any allegations of abuse.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern and this area of non-compliance was previously issued as a Written Notification on January 4, 2016, under Critical Incident inspection #2015_303563_0055. [s. 20. (1)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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 or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure that when a person who had reasonable grounds to suspect that any abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that when a person who had reasonable grounds to suspect that any abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

In an interview, a resident said that they witnessed a resident expressing a certain behaviour towards another resident.
The resident said "I wrote a letter and gave it to the ADOC, they took it from me but they did not talk to or ask me any questions about it".

In a telephone interview, the ADOC said that they left the home earlier in the month. They recalled taking a letter from the resident but it was related to personal concerns with a PSW and not related to abuse.
The ADOC said that they do not recall any allegations of abuse from the

resident. ADOC said "all letters received were documented in the notes and I gave all the letters to the DOC or Administrator".

In a clinical record review, a progress note by the ADOC on a certain date showed that the resident requested to speak with the ADOC in regards to their concerns (observing residents, staff and their feelings). The resident handed ADOC two letters, one from PSW staff and one of the notes that the resident wrote.

A clinical record review showed no further notes from the ADOC about the letters.

In an interview, the Administrator said that they knew the ADOC received a letter of concerns from the resident and thought that it was addressed right away. The Administrator was not able to find those letters.

A review of the Critical Incident System (CIS) showed there was no submission of those allegations of abuse to the Director.

The Administrator said that the expectation was for the ADOC to report allegation of abuse immediately to the Director.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern and this area of non-compliance was previously issued as a:
Written Notification and Compliance Order on March 08, 2016, under Resident Quality Inspection #2016_229213_0005, Compliance Order was complied with on April 26, 2016.
Written Notification and Compliance Order on January 4, 2016, under Complaint inspection #2015_303563_0054, Compliance Order was closed with link to inspection #2016_229213_0005.
Written Notification and Voluntary Plan of Correction on June 26, 2015, under Complaint inspection #2015_229213_0022.
Written Notification and Voluntary Plan of Correction on May 20, 2015, under Resident Quality Inspection #2015_416515_0013.
Written Notification on February 13, 2015, under Critical Incident inspection #2015_260521_0007. [s. 24. (1) 2.] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Order / Ordre :

The licensee shall ensure that screening measures including criminal reference checks are conducted in accordance with the regulations before hiring staff and accepting volunteers.

Grounds / Motifs :

1. The licensee has failed to ensure that screening measures including criminal reference checks were conducted in accordance with the regulations before hiring staff and accepting volunteers.

A review of Complaint IL-52251-LO showed that staff have been hired in the home without a police check.

An employee file review of a certain number of staff showed that some had no police check completed with vulnerable sector screening.

In an interview, the DOC acknowledged that every staff needed to have a police check with vulnerable sector clearance before they work in the home with the residents.
The DOC said that the home sometimes hired staff and completed orientation before they had the police check results as it takes time for the police report to come back.

The Inspector completed a review of the employee files with the DOC. The DOC verified the findings of the Inspector's employee file review.

The DOC did not know how staff started working with no criminal checks completed, and said that the expectation was for staff not to work with residents unless all of their employment requirements were done.

In an interview, the Administrator said that the expectation was for all the employees hired by the home to have a criminal record check completed with vulnerable sector screening before being hired by the home.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern and similar area to this non-compliance was previously issued as a Written Notification and Voluntary Plan of Correction on March 3, 2015, under Complaint inspection #2015_260521_0004. [s. 75.] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 004

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

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 shall ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically but not limited to, Medication/Treatment Administration Records.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The Inspector was informed during the inspection that a RN was directed by a management team member to allow an agency RPN to administer medications under the RN's log in access. The RPN administered medications and signed as if the RN completed the medication pass. The RPN made two medication errors that would appear under the RN's name.

A review of a medication incident report completed by the home on a specific date showed the following in the manager's response "RPN's first time at ECV (Earl's Court Village) from an agency. RPN used RN's access code as RPN did not have a Login to Point Click Care (PCC) or the Electronic Medication Administration Record (EMAR). RN got instructions from management".

In an interview, the RPN said that they worked in the home on a certain date for their first shift, they got four hours orientation on the same day before their shift started.

The RPN said that they did not have their own access to the EMAR or PCC and the RN signed them into the EMAR to administer medication under their log in. The RPN acknowledged that they administered the medications under the RN's log in and that on EMARs it was the RN's signature that was showing as the nurse who administered the medications.

In an interview the RN said that on that date the agency RPN had no log in access to PCC or EMARs.
The RN said that the CEO/President was in the building and they advised them to log in and permit the RPN to sign under their name when the medication was administered.
The RN acknowledged that the RPN made two medication errors on that shift and that those errors were logged under the RN's name.

A review of the home's policy Medication/Treatment Administration Records, index: NAM-G-90, effective date: January 2014, showed that when a Registered Staff administers medication/treatment, this person must initial MAR/TAR sheet under correct date and time of administration or assign their electronic initials with the electronic medication and treatment administration software.

In an interview, the Administrator acknowledged that the home's policy was not complied with and said that it was the home's expectations that nurses administer medications under their own log in. If the log in was not available then they would administer and sign on paper MARs.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated, this area of non-compliance was previously issued as a Written Notification and Voluntary Plan of Correction on March 8, 2016, under Resident Quality Inspection #2016_229213_0005.
Written Notification and Voluntary Plan of Correction on June 5, 2015, under Resident Quality Inspection #2015_416515_0013.
Written Notification and Voluntary Plan of Correction on February 25, 2015, under Complaint inspection #2015_259520_0003.
Written Notification on February 23, 2015, under Critical Incident inspection #2015_260521_0007.
Written Notification and Compliance Order on October 21, 2014, under Complaint inspection #2014_232112_0067. Compliance Order was complied with on December 19, 2014. [s. 8. (1) (b)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Multiple complaints received through the Ministry of Health and Long-Term Care ACTION Line related to staffing shortage impacting residents' care.

A. A review of the staff schedules with the Administrator showed that for a specific period of time the home worked short staffed. The Administrator said that they currently had one RN, four RPN and five PSW lines vacant.
The Administrator said that in a specific period of time several management staff had left the home, some of which were replaced, others were still in orientation and some were in the process of recruitment, this added a lot of stress on managers and created a lot of mistakes in payroll and scheduling including the

nursing department.
The Administrator said that the Dietary Services Manager (DSM) was feeling overwhelmed and unsupported especially after adding payroll and scheduling to their duties. DSM resigned and a new DSM had just started.
The Activity Manager also resigned for the same reasons, they did not feel supported and the work load was unmanageable.
The ADOC resigned and left the home early August, the DOC was on leave from August 4-28.
The Administrator said that they analyzed and tracked when the sick calls and shortages occurred most, they requested to over staff on those occasions to ensure proper staffing but this request was denied by the corporate office due to budget concerns.
The Administrator said that they also suggested hiring full time rather than part time or casuals, but also was denied by the corporate office due to budget reasons, as full time now require benefits and so on.

B. In an interview, a resident said an identified home area was always short of staff, the resident had to wait for everything. The resident said that they required assistance to go to the toilet. They were continent and they used to wait a long time for staff to respond to the call bell. They said that they soiled their pants with urine and stool because of the delay in response. A review of the call bell log for a certain period of time showed that the resident on multiple occasions waited from 13-36 minutes for staff to respond to the call bell.

C. In an interview, a resident said that the home was short staffed mostly on the weekends, and for all disciplines. The resident said that they were affected by staffing shortages as they require assistance to eat and to go to the toilet. On multiple occasions they had to wait an hour to be fed and an hour to be changed from a soiled brief. The resident expressed real stress and fear as this may result in skin breakdown and they did not want any sores as a result of that.
A review of the missing task report for a specific period of time showed that the resident had 42 missing tasks for routine toileting, bladder and bowel tasks.
The RAI Coordinator said in an interview that they were aware of the missing tasks that were not completed or signed for the residents due to shortage of staff. They said that they run those reports and give them to the DOC to follow up with staff and to the Administrator to address sufficient staffing.

D. In an interview, a resident's family member said that the resident required certain assistance for toileting, and required assistance with feeding. The family

member said that they came to the home every day to ensure the resident received the care they needed. The family member said that they rang the call bell for assistance and the average wait time was around 10 minutes, however when the staff responded to the call bell they would shut it off and say they will return with a partner to assist and this may take up to 30 minutes.
A review of the call bell log for a certain period of time showed that the resident on multiple occasions waited 10-26 minutes for staff to respond to call bell.

E. In an interview, a resident said that they were short of staff a lot, even when fully staffed they seemed too busy to handle the work. The resident said that they wore an incontinent product and were supposed to be toileted at a certain frequency. The resident said between the time they got up in the morning to the time they went to bed in the evening they would probably get toileted twice a day only. The resident said that they were usually soaked through with urine and this made them mad and embarrassed. The resident said that they had to change the product they used to a different type so it could hold more urine because the staff can not change them at the required frequency. The resident also said that residents, including themself, were not given baths twice a week.
A review of the resident plan of care showed that the resident was on a toileting routine at a certain frequency. A review of the task record for a certain period of time showed that the resident had 34 missing tasks for the toileting routine. A review of the task record for a certain period of time showed that the resident did not have two baths a week for the period of two weeks.
Observations on a certain date and time showed the resident was not toileted during this time. A PSW said that they were not able to toilet the resident as per their toileting routine due to staffing shortages.

F. Observations on a certain date and time showed a resident was in the common area using a specific restraint device. The resident was not approached, turned, repositioned and the restraint was not removed and reapplied and the resident was not toileted.
A review of the plan of care and the task list report for a certain period of time showed the following:
Restraint Check at specific times. This task was not signed 73 out of 315 times (23 percent).
Monitor-turning and repositioning at specific times. This task was not signed 48 out of 252 times (19 percent).
Restraint-removed for repositioning and reapplied at specific times. This task was not signed 34 out of 147 times (21 percent).

The resident received one bath a week for two weeks.
A PSW said in an interview that they were not able to provide care for the resident such as toileting, positioning, removing and reapplying restraint since the resident was put in the common area in the morning and staff would not be able to provide care until after lunch.

G. In an interview, a PSW said that they were not able to change and position a certain resident as required which caused skin break down. The resident did not receive two baths a week during a specific two week period of time.
In an interview, a RPN said that they completed a skin assessment on the resident on a certain date, the skin was intact. They reassessed the resident two days later and the resident had three areas of altered skin integrity.
A review of the resident's task list report showed that the resident was on a toileting program at specific times. On the dates between the assessments this task was not signed five out of 12 times (42 percent).
A review of the skin and wound assessment showed that the resident had new areas of concerns related to altered skin integrity.

H. Observations by inspectors throughout the inspection showed that at lunch time some residents waited 30-45 minutes to be served their drinks and lunch. Other residents waited 20-30 minutes to get their fruits or deserts.

I. In an interview, a PSW said that when they work short staffed they were not able to complete daily tasks like toileting, positioning, restraint safety checks and assisting residents to bed on time. They were not able to complete two baths a week for residents.

In an interview, a PSW said that they worked short staffed almost every day, especially on the weekends. When short staffed, residents were not receiving the proper care they needed like toileting, safety checks, restraint checks and positioning and staff were not able to complete all the care needed for the residents as per the plan of care.
The PSW said that in addition to previous examples, another resident did not receive two baths a week for a specific two week period of time. This was confirmed by a review of the task records.

In an interview, a PSW said that they worked short mostly on weekends. They were not able to complete baths for residents and two baths a week were not being done. Staff were not able to complete tasks such as safety checks,

repositioning, toileting and assisting residents in and out of bed on time.
The PSW said "there were residents that required assistance in feeding and it usually took us an hour and a half to finish meal service".

In an interview, a RPN said that they worked short staff mostly on the weekends.

When the home was short staffed, breakfast or lunch service and medication pass took at least an hour and a half to complete.
The RPN said that working short resulted in tasks such as positioning, toileting and restraint checks for residents not being done.

In an interview, the RN said that they worked short staffed and this put the residents at risk. Staff did not get the support that they needed to provide proper care to residents.
PSWs were not able to complete tasks necessary for resident's safety and were not able to complete resident care tasks because they were short staffed.
Nurses were covering on two units which caused delays in providing care and administering medications.

In an interview, the RN said that they worked on a certain date and on that day they were short of nurses.
The RN called the RCC and the Administrator but no help was provided.
The CEO/President was in the building and told them to do what they could and finish on time.
The RN said that they covered two units on that day. They were delayed in providing treatment and medications within the one hour before or after scheduled times. The RN acknowledged that the medication pass took around three and a half hours to complete.
The RN said that management were informed that staffing shortages were impacting resident care. Staff were told to do what they could.

In an interview, a RPN said that they currently were doing the schedules. The RPN said that different hiring strategies were suggested to the corporate office to address the staffing shortages but those suggestions were declined due to budget concerns.
The RPN said that the Administration of the home were aware that the staff were not able to complete all residents' related tasks as a result of the staffing shortages.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern, this area of non-compliance was previously issued as a:
Written Notification and Compliance Order on March 8, 2016, under Resident Quality Inspection #2016_229213_0005. Compliance Order was complied with on April 14, 2016.
Written Notification and Voluntary Plan of correction on December 24, 2014, under Complaint inspection #2014_303563_0061. [s. 31. (3)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 22nd day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Ali Nasser

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