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 prévue le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2018;	2017_607523_0032 (A1)	016143-17, 018214-17	Complaint

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
108 Jensen Road LONDON ON N5V 5A4

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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension for the Compliance Date from January 31, 2018, to February 28, 2018.

Issued on this 30 day of January 2018 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 14, 15, 16, 17, 20, 21, 22 and 23, 2017.

PLEASE NOTE: A Written Notification under O. Reg.79/10, r. 8 (1) b, identified in this inspection will be issued under a Critical Incident inspection #2017_607523_0033, Log #007403-17, 011823-17, 014514-17, 014821-17, 015976-17, 017624-17, 021790-17, 022211-17, 023214-17 and 024872-17.

The following intakes were completed concurrently with this inspection as follows:

Log #014514-17 / CIS #3047-000020-17 related to alleged resident to resident abuse.

Log #017624-17 / CIS #3047-000027-17 related to a resident's fall.

Log #021790-17 / CIS #3047-000032-17 related to a resident's fall.

Log #023214-17 / CIS #3047-000038-17 related to a resident's transfer.

Log #024872-17 / CIS #3047-000044-17 related to alleged resident to resident abuse.

Log #025974-17 / CIS #3047-000049-17 related to alleged resident's neglect.

Log #011823-17 / CIS #3047-000018-17 related to alleged resident to resident abuse.

Log #014821-17 / CIS #3047-000021-17 related to alleged staff to resident abuse.

Log #015976-17 / CIS #3047-000024-17 related to alleged resident to resident abuse.

Log #022211-17 / CIS #3047-000031-17 related to a missing controlled substance.

Log #027065-17 / CIS #3047-000055-17 related to misappropriation of medications.

Log #007403-17 / SAC Report #15285 related to alleged staff to resident abuse.

Log #023421-17 a Follow up inspection related to screening measures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Dietary Services Manager, Maintenance Manager, Resident Care Coordinator, Physiotherapist, Locum Physician, 13 registered staff members, 16 Personal Support Workers (PSW), two family members and 15 residents.

The inspector(s) also 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:

Falls Prevention

Hospitalization and Change in Condition

Personal Support Services

Skin and Wound Care

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

2 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On a certain date a family member for a specific resident told an Inspector that they had brought forward a concern to the staff in the home multiple times regarding a resident's specific care need and that staff were not completing a specific task. This family member said they had posted signs in the resident's room to remind staff to complete this specific task.

On a certain date a Registered Practical Nurse (RPN) acknowledged the resident's specific care need and said that they check on the resident when providing care to them to ensure that the care need was met and the Personal Support Worker (PSW) staff were checking the resident as well. The RPN said there was a sign posted in the resident's room to remind staff to complete this specific task.

On a certain date a PSW said that the resident tended to exhibit a certain behaviour and that the family had expressed concerns that the specific task was not being completed regularly. The PSW said that there was a task on Point of Care (POC) for the resident's specific care need to be completed at specific times

but sometimes the resident would refuse to have this task completed.

On a certain date a Registered Nurse (RN) was asked by Inspector if they were aware of the specific family concerns. The RN said that there had been no concerns brought forward directly to them but they were aware that the family had concerns as there was a note posted in the resident's room to remind staff to complete a specific task to address the resident's specific care need.

The clinical record for the resident included the following documentation:
- A progress note by a RN completed on a specific date showed that a resident's family member was complaining about resident's specific care need. Asked whether PSW's had completed a specific task. PSW was there during the confrontation and said that they had completed the task. Family member was complaining that resident's care need had not been met and the specific task was not being completed.
- The plan of care for the resident showed the focus altered certain functional ability related to a specific condition and the interventions within this plan of care included a specific interventions to be provided as needed.
- The plan of care for the resident showed the focus altered certain ability to complete certain tasks due to specific medical condition.
- No observed assessment or reference in the plan of care related to the resident's specific care need or behaviours exhibited while completing specific tasks.
- The Point of Care (POC) tasks for specific period of time included a specific task to be completed pre/post meals and there was no documentation to indicate this was either completed or that the resident refused for 52 out of 186 (28 per cent) of the times indicated for the task to be completed.
- The Point of Care (POC) tasks for specific period of time showed that the scheduled specific tasks were refused two out of nine times (22 per cent) of the times indicated for the task to be completed.

On a certain date Inspector reviewed the progress notes for the resident with a RN and the RN acknowledged that they had been made aware of a concern from the family member of the resident regarding the resident's specific care needs. The RN said that they looked into the concern at the time and no concerns noted as the family member had completed the specific task. The RN said that they were not aware of any behaviours this resident had in relation to their specific care need. The RN informed the family member that they would follow-up on the concern and they thought they had left a note for the Director of Care (DOC).

On a certain date the Administrator told Inspector that they were familiar with the resident and that the family had expressed concerns with a specific care need at a certain period of time. Administrator said at that time they had followed-up with staff and added a task to POC to ensure staff were completing the specific task and addressing the resident's care need. Administrator said they had not been made aware of the recent family's concern regarding the resident's specific care need or behaviours related to this specific care need. Administrator reviewed the clinical record for the resident and acknowledged that there was a progress note completed on a certain date which identified the family concern related to the resident's specific care need. Inspector reviewed the POC documentation for the specific period of time with Administrator and they acknowledged that it was difficult to determine if the task had been provided to the resident or if the resident refused the care due to the missing documentation. Administrator reviewed the plan of care for the resident and acknowledged that apart from telling staff to reapproach when the resident refused care it did not address the specific care need or behaviours related to that need. Administrator said that it was the expectation in the home that this type of behaviour would be assessed and included in the plan of care.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to the resident. The scope of the non-compliance was isolated, this area of non-compliance was previously issued as a:
Written Notification on April 13, 2017, under Resident Quality Inspection Log #005564-17 and inspection #2017_536537_0015.
Written Notification and Director Referral on June 24, 2016, under Follow up Log #008410 and inspection #2016_229213_0018.
Written Notification and Compliance Order on May 11, 2016, under Follow up Log #008403-16 and inspection #2016_229213_0013.
Written Notification and Compliance Order on March 8, 2016, under Resident Quality Inspection Log #001309-16 and inspection #2016_229213_0005.
Written Notification and Voluntary Plan of Correction on May 28, 2015, under Complaint Log #008221-15 and inspection #2015_182128_0011.
Written Notification and Voluntary Plan of Correction on May 20, 2015, under Resident Quality Inspection Log #L-001936-15 and inspection #2015_416515_0013. [s. 6. (2)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan had not been effective.

On a certain date a family member for a specific resident told Inspector that they went to visit the resident on a specific date and they noticed that the resident was very tired and did not seem well. This family member said that at that time they became aware that the resident had been deteriorating for a certain number of days with specific signs and symptoms and was concerned that the staff in the home did not identify the change in the resident's status earlier. They requested the resident be sent to the hospital. This family member said they did speak with the Director of Care (DOC) about these concerns.

A clinical record review for the resident showed that the resident had a fall with no injury noted at the time, the resident’s had a change in condition. Resident’s family were visiting the resident and voiced concerns that the resident was deteriorating. Resident was sent to hospital.

There was no documented evidence that this resident had been assessed or the plan of care was revised related to the specific change in vital signs by a RN or physician between the post fall assessment completed and the transfer to hospital.

On a certain date a RPN reported that usually they did assess residents' vital signs weekly or monthly and when there had been a fall and the resident was on a HIR they would assess more often. The RPN said if something changed with a resident they were expected to notify the Registered Nurse who would then decide if the physician needed to be contacted. Inspector reviewed with the RPN the progress note they had documented on a certain date and the RPN acknowledged that they had documented that the resident’s specific vital sign was very low. The RPN said the action they had taken was to notify the family who said they wanted the resident to be monitored. The RPN said they thought they had reported that concern to the RN for assessment but they had not documented this action.

On a certain date a RN said they did not recall any of the details of the fall that the resident had on a certain date including their involvement in the fall assessment. Inspector reviewed RN’s post fall documentation with them. The RN acknowledged that they had documented in this assessment that the resident’s specific vital sign was considered to be low but said they thought maybe that was normal for the resident. The RN said they thought that they had called the doctor to notify them and thought they were told just to monitor the resident and acknowledged that the details of this referral for assessment had not been documented.

On a certain date a RN said they were familiar with the resident but did not recall any details regarding a fall or change of condition. The RN acknowledged that they had been working in the home as the RN on certain dates. The RN said they did not recall being notified of any concerns regarding the resident. The RN said that their usual practice was to document any assessment that they completed on residents in the progress notes and would follow-up with physician if needed. The RN said that a specific low vital signs would be of concern and would need to be assessed.

On a certain date a Physician reported that they had assessed the resident after the fall on a certain date and at that time there were no concerns identified regarding the resident’s well-being. The Physician said they had not been notified by the staff in the home after that assessment regarding concerns with the resident’s specific vital sign or overall health status until after they were sent to hospital. The Physician said it was their expectation that they would be notified of a low specific vital sign or change in condition in order for the resident to be assessed and if needed treatments changed.

During an interview with the DOC, they said that the practice in the home after a fall was that the registered staff were to assess the resident which included assessing vital signs. When asked how the staff were to assess the vital signs they said that they were to monitor and document as per the head injury routine. The DOC said that it was the expectation that any deviation from the norm would be assessed and followed-up with the RN and the physician. The DOC said it was the expectation that the notification of a RN or physician for assessment would be documented. Inspector reviewed the clinical record for the resident with the DOC including the documented vital sign, progress notes and HIR. The DOC said that it was the expectation in the home that staff would use critical thinking skills and were expected to assess, document and follow-up on a low specific vital sign. The DOC said that the specific vital sign identified on the post fall assessment was low and indicated that the resident potentially needed to be assessed for a specific intervention.

Based on these interviews and clinical record review the home failed to reassess the resident and revise the plan of care when the resident's condition, changed and the care set out in the plan of care was not effective.

During the inspection this non-compliance was found to have the severity level of actual harm/risk or potential for actual harm/risk to the resident. The scope of the

non-compliance was a pattern, this area of non-compliance was previously issued as a:
Written Notification and Voluntary Plan of Correction on July 8, 2016, under Complaint Log #017346-16 and inspection #2016_303563_0017.
Written Notification and Voluntary Plan of Correction on May 11, 2016, under Follow up Log #008403-16 and inspection #2016_229213_0013.
Written Notification and Compliance Order on March 8, 2016, under Resident Quality Inspection Log #001309-16 and inspection #2016_229213_0005.
Written Notification and Voluntary Plan of Correction on February 12, 2015, under Critical Incident Log #006363-14 and inspection #2015_260521_0003.
Written Notification and Voluntary Plan of Correction on December 10, 2014, under Complaint Log #007377-14 and inspection #2014_183135_0092. [s. 6. (10)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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 care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On a certain date a family member for a specific resident told Inspector that in a certain period of time they had brought forward a concern to staff regarding an area of altered skin integrity on the resident. This family member reported they discussed the skin concern with a registered staff in the home and had taken pictures. This family member forwarded two pictures to the Ministry of Health and Long-Term Care (MOHLTC) and stated these were images of resident's specific area with the altered skin integrity.

On a certain date a Registered Practical Nurse (RPN) said that the usual practice in the home was to assess any new altered skin integrity areas using the skin assessment form in Point Click Care (PCC) and that there was a specific form they were to use for this specific type of altered skin integrity. When asked if the resident had this specific type of altered skin integrity in the specific period of time, the RPN said that there was a concern that had been brought to their attention by the resident's family member but the RPN was not sure how it occurred. The RPN

said that when they saw the altered skin integrity area it was small and was not fresh and could not recall if there was a dressing or a treatment. The RPN said they had not been involved in documenting an assessment of this altered skin integrity.

On a certain date a Personal Support Worker (PSW) said that the resident had a specific area of altered skin integrity but could not recall exactly when that had occurred. The PSW said that the family for this resident had expressed that they thought the altered skin integrity was caused by a staff member.

On a certain date a Registered Nurse (RN) Wound Care Lead said that it was the expectation in the home that any new altered skin integrity would be assessed in PCC using the initial assessment form and there was a special skin tear assessment form. The RN said it was expected that the RPN on the floor who was notified or discovered the any new skin integrity concern would completed the assessment. RN said they had not been notified that the resident had an alteration in skin integrity in the specified period of time and had not been involved in assessing this altered skin integrity. The RN reviewed the skin assessments and treatments that had been documented in PCC for the resident and told Inspector that there had not been an initial assessment completed on this altered skin integrity.

The clinical record for the resident included the following documentation:
- A progress note on a certain date completed by a RPN showed that RPN helped resident in bed, completed certain treatments, family member came in and complained of what happened on the weekends as resident sustained a specific alteration in skin integrity caused by a staff member and also stated that pictures from phone shown to RPN and wanted to talk to someone before they call the ministry. Advised family member to speak with RN as they can go more about it. Writer also informed that concerns were brought out to the other RN the other day.
- No documented specific altered skin integrity Assessment in the PCC Assessment section for the resident's specific area of altered skin integrity.

On a certain date the Director of Care (DOC) said that they had been made aware by staff of a concern from the family of the resident of an area of altered skin integrity that the family had reported was caused by a staff member when providing care. The DOC followed-up with Inspector and said that they checked with registered staff and were told that the altered skin integrity concern had been assessed and it was identified to be small in size. The DOC acknowledged to

Inspector that this area of altered skin integrity had not been assessed using the assessment form in PCC. The DOC said the expectation when there was an altered skin integrity identified that it would be referred to the skin and wound care nurse, it would be assessed in PCC and if needed a treatment would be started.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to the resident. 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 Log #001309-16 and inspection #2016_229213_0005.
[s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

Issued on this 30 day of January 2018 (A1)

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : ALI NASSER (523) - (A1)

Inspection No. / No de l'inspection : 2017_607523_0032 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 016143-17, 018214-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jan 30, 2018;(A1)

Licensee / Titulaire de permis : SHARON FARMS & ENTERPRISES LIMITED
108 Jensen Road, LONDON, ON, N5V-5A4

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

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 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. 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 shall ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change and the care set out in the plan has not been effective.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On a certain date a family member for a specific resident told an Inspector that they had brought forward a concern to the staff in the home multiple times regarding a resident's specific care need and that staff were not completing a specific task. This family member said they had posted signs in the resident's room to remind staff to complete this specific task.

On a certain date a Registered Practical Nurse (RPN) acknowledged the resident's specific care need and said that they check on the resident when providing care to

them to ensure that the care need was met and the Personal Support Worker (PSW) staff were checking the resident as well. The RPN said there was a sign posted in the resident's room to remind staff to complete this specific task.

On a certain date a PSW said that the resident tended to exhibit a certain behaviour and that the family had expressed concerns that the specific task was not being completed regularly. The PSW said that there was a task on Point of Care (POC) for the resident's specific care need to be completed at specific times but sometimes the resident would refuse to have this task completed.

On a certain date a Registered Nurse (RN) was asked by Inspector if they were aware of the specific family concerns. The RN said that there had been no concerns brought forward directly to them but they were aware that the family had concerns as there was a note posted in the resident's room to remind staff to complete a specific task to address the resident's specific care need.

The clinical record for the resident included the following documentation:
- A progress note by a RN completed on a specific date showed that a resident's family member was complaining about resident's specific care need. Asked whether PSW's had completed a specific task. PSW was there during the confrontation and said that they had completed the task. Family member was complaining that resident's care need had not been met and the specific task was not being completed.
- The plan of care for the resident showed the focus altered certain functional ability related to a specific condition and the interventions within this plan of care included a specific interventions to be provided as needed.
- The plan of care for the resident showed the focus altered certain ability to complete certain tasks due to specific medical condition.
- No observed assessment or reference in the plan of care related to the resident's specific care need or behaviours exhibited while completing specific tasks.
- The Point of Care (POC) tasks for specific period of time included a specific task to be completed pre/post meals and there was no documentation to indicate this was either completed or that the resident refused for 52 out of 186 (28 per cent) of the times indicated for the task to be completed.
- The Point of Care (POC) tasks for specific period of time showed that the scheduled specific tasks were refused two out of nine times (22 per cent) of the times indicated for the task to be completed.

On a certain date Inspector reviewed the progress notes for the resident with a RN and the RN acknowledged that they had been made aware of a concern from the family member of the resident regarding the resident's specific care needs. The RN said that they looked into the concern at the time and no concerns noted as the family member had completed the specific task. The RN said that they were not aware of any behaviours this resident had in relation to their specific care need. The RN informed the family member that they would follow-up on the concern and they thought they had left a note for the Director of Care (DOC).

On a certain date the Administrator told Inspector that they were familiar with the resident and that the family had expressed concerns with a specific care need at a certain period of time. Administrator said at that time they had followed-up with staff and added a task to POC to ensure staff were completing the specific task and addressing the resident's care need. Administrator said they had not been made aware of the recent family's concern regarding the resident's specific care need or behaviours related to this specific care need. Administrator reviewed the clinical record for the resident and acknowledged that there was a progress note completed on a certain date which identified the family concern related to the resident's specific care need. Inspector reviewed the POC documentation for the specific period of time with Administrator and they acknowledged that it was difficult to determine if the task had been provided to the resident or if the resident refused the care due to the missing documentation. Administrator reviewed the plan of care for the resident and acknowledged that apart from telling staff to reapproach when the resident refused care it did not address the specific care need or behaviours related to that need. Administrator said that it was the expectation in the home that this type of behaviour would be assessed and included in the plan of care.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to the resident. The scope of the non-compliance was isolated, this area of non-compliance was previously issued as a:
Written Notification on April 13, 2017, under Resident Quality Inspection Log #005564-17 and inspection #2017_536537_0015.
Written Notification and Director Referral on June 24, 2016, under Follow up Log #008410 and inspection #2016_229213_0018.
Written Notification and Compliance Order on May 11, 2016, under Follow up Log #008403-16 and inspection #2016_229213_0013.
Written Notification and Compliance Order on March 8, 2016, under Resident Quality

Inspection Log #001309-16 and inspection #2016_229213_0005.
Written Notification and Voluntary Plan of Correction on May 28, 2015, under Complaint Log #008221-15 and inspection #2015_182128_0011.
Written Notification and Voluntary Plan of Correction on May 20, 2015, under Resident Quality Inspection Log #L-001936-15 and inspection #2015_416515_0013.
[s. 6. (2)] (630)

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

Feb 28, 2018(A1)

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

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

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 30 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ALI NASSER - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : London