



**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**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 24, 2015	2015_229213_0060	010427-15	Complaint

Licensee/Titulaire de permis

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

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

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

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

RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): December 7, 8, 9, 2015

This complaint related to care issues and lack of response to a complaint was completed while in the home with Inspector #563, and while completing four other complaints, eight critical incident inspections and a follow up inspection.

PLEASE NOTE: A Written Notification (WN #1), and Compliance Order #001 under O. Reg 79/10, s. 101, identified in this inspection (Log#010427-15) will be issued under a Follow Up Inspection #2015_303563_0052 Log #033924-15 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Geriatric Clinical Nursing Specialist, a Registered Practical Nurse, a Personal Support Worker, a resident and a family member.

The inspector also made observations and reviewed the complaints log, policies, education records, health records and other relevant documentation.

**The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints**

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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



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Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).

(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :



1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A phone interview with a family member for resident #106 revealed on an identified date, the resident was found by the family requiring and not receiving care. Staff advised the family that the resident refused care that day.

Record review of the electronic health record revealed documentation in progress notes for resident #106 indicated this resident exhibited responsive behaviours on eleven occasions during time period of August to November, 2015. A progress note indicated the resident was discharged from the BSO (behavioural support) program. Review of physician's orders revealed the physician increased the dose of an identified medication due to ongoing and increasing responsive behaviours.

Record review of the plan of care for resident #106 revealed no identification of responsive behaviours, goals or interventions related to responsive behaviours.

In an interview on December 9, 2015, the Administrator and Acting Director of Care confirmed the home's expectations that the responsive behaviours documented in the progress notes should have been identified and assessments completed. They confirmed that goals, interventions and strategies should have been identified and documented in the resident's plan of care. [s. 53. (4)]



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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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 24th day of December, 2015

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

Original report signed by the inspector.