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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2015	2015_416515_0013	L-001936-15	Resident Quality Inspection

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

RAE MARTIN (515), ALI NASSER (523), DONNA TIERNEY (569), RUTH HILDEBRAND (128)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 28, 29, 30, May 1, 4, 5, 6, 7, 8, 11, and 12, 2015.

Critical Incidents CI-002157-15 and CI-006152-15 related to abuse of residents and Complaints 003986-15 related to laundry, 004846-15 related to improper care of residents, 002719-15 related to responsive behaviours, 003929-15 related to neglect of a resident, 006108-15 related to abuse of a resident and 008221-15 related to multiple care concerns were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Licensee, Administrator, Acting Administrator, Director of Care, Director of Facility Services, Director of Recreation, Director of Quality Improvement, Director of Dietary Services, Office Manager, RAI Coordinator, Registered Dietitian, 2 Registered Nurses (RN), 10 Registered Practical Nurses (RPN), 21 Personal Support Workers (PSW), a Dietary Aide, a Laundry Aide, a Housekeeping Aide, a Physiotherapy Assistant (PTA), 40+ Residents and 6 Family Members.

The Inspector(s) also toured all resident home areas and common areas, observed residents and the care provided to them, resident-staff interactions, recreational activities, dining service, medication administration, medication storage areas, laundry room, posting of required information, general maintenance, cleanliness and condition of the home. Health care records and plans of care for identified residents were reviewed, as well as the home's internal investigation notes, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Responsive Behaviours
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (1)	CO #001	2015_260521_0004	523
O.Reg 79/10 s. 229. (5)	CO #001	2015_260521_0016	515
O.Reg 79/10 s. 90. (2)	CO #001	2015_260521_0014	515

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. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee has failed to implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents.

A review of the Quality Improvement and Required Programs LTCH Licensee Confirmation Checklist completed by the Administrator and dated April 30, 2015, revealed the Quality Improvement review system has not been implemented in the home.

The Director of Quality Improvement confirmed that data has not been entered into the review system and acknowledged the absence of direct care staff member representation on the Quality Improvement Committee.

The Director of Recreation confirmed there have been no meetings held of the Quality Improvement Committee.

The Administrator confirmed that the data has not been entered into the review system to enable monitoring, analysis and evaluation of the information for quality improvement and also confirmed the expectation that the home implement a quality improvement and utilization review system. [s. 84.]

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written policy that dealt with doors leading to secure outside areas to permit or restrict unsupervised access to those areas by residents.

Observations made of the second, third and fourth floor balcony doors on three identified dates, revealed that the doors leading to the balconies were unlocked and unsupervised during the day. Residents were observed to be out on those balconies unsupervised.

On May 5, 2015, the Director of Quality Improvement confirmed that the door to the fourth floor balcony was unlocked and unattended and also confirmed that the home does not have a written policy regarding doors leading to secure outside areas. [s. 9. (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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents to be afforded privacy in treatment and in caring for his or her personal needs were fully respected and promoted.

During two separate incidents, three residents were observed in a common area, receiving specific treatments by a health care provider and a registered team member.

Two registered staff members confirmed that receiving care in a common area was not documented in the plans of care for the identified residents.

The Director of Quality Improvement and two registered staff members confirmed that it was the home's expectation that residents be afforded privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]

2. The licensee has failed to ensure that the right of residents to have his or her personal health information kept confidential was fully respected and promoted.

During three separate incidents, on two identified home areas, the chart rack containing residents' personal health information (PHI) was observed to be unlocked and unattended. PHI was accessible to residents.

During one incident, a laptop was observed to be on with resident PHI visible on the screen.

A registered team member and the RAI Coordinator confirmed that PHI was accessible to residents.

The Director of Facility Services and the Director of Care confirmed the expectation that every resident has the right to have his or her PHI kept confidential. [s. 3. (1) 11. iv.]

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 the rights of residents are fully respected and promoted and that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs as well as the right to have his or her personal health information kept confidential, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On an identified date, two inspectors observed an outside gate leading to the home's parking lot to be open on the east side of a secure garden area located behind the home. The gate had a key pad mounted on both the inside and outside of the gate. The inspectors observed five residents in various locations within the area, a companion to one resident and a landscape worker picking up leaves on the west side of the area.

The Director of Recreation and Director of Care both confirmed the secure garden area gate should be kept closed and locked to ensure resident safety.

2. On an identified date, a room was observed open and unattended with a resident in the room.
A curling iron that was hot to the touch was noted on the counter.
The Director of Recreation confirmed the observation.

On a subsequent date, the room was again observed open and unattended with a resident in the room.
Two curling irons that were hot to the touch were observed in the unlocked cupboard.
A staff member confirmed that the resident had been left unattended in the room.

The Acting Administrator indicated that the expectation was that residents should not be left unattended in the identified room to ensure they were safe. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Observations made throughout the Resident Quality Inspection revealed that Resident #08 used an assistive device when seated in his/her wheelchair.

In an interview, the Resident revealed that he/she prefers to have the assistive device, as it provides a greater feeling of safety.

An interview with a PSW revealed that the resident likes to have the assistive device and the staff apply it when the resident is in his/her wheelchair.

Review of the clinical record revealed there was no direction in the care plan on the use of the assistive device.

The Director of Quality confirmed there was no documented evidence of use of the assistive device and the home's expectation was that the plan of care would set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based

on an assessment of the resident's needs and preferences.

An interview with the Power of Attorney for Resident #03 revealed that:
a) The resident’s previous routine and preference was to have his/her hair groomed daily and the resident would like to continue this routine.
b) The resident wears dentures and requires the application of denture adhesive to enable the resident to chew properly.

Clinical record review revealed that there was no documented evidence in the plan of care that addressed these needs and preferences of the resident.

An interview with the Director of Quality Improvement confirmed that the plan of care was not based on an assessment of the resident’s needs and preferences and confirmed that it was the home’s expectation that the plan of care was based on an assessment of the resident's needs and preferences. [s. 6. (2)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Clinical record review of Resident #04's care plan, revealed the resident was not allowed to ambulate without assistance and he/she was to have a one person assist for locomotion in his/her room, in the corridor, on the unit and off the unit.

Observation of Resident #04 revealed he/she was walking independently using an assistive device both on and off the unit.

Interview with the resident revealed he/she did not require assistance from staff for ambulation.

A PSW confirmed that the resident now ambulated independently.

An interview with the Director of Quality Improvement confirmed that the care provided to Resident #04 with respect to ambulation was not as specified in the plan. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide care to the resident, 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, and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: 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 all policies were complied with.

A review of the home's policy entitled NAM-F-60 Weights, dated January 2014, revealed that "All Residents will be weighed on admission and monthly after."

Clinical record review revealed 20/40 (50%) of residents were not weighed monthly.

The Director of Care confirmed the results of the review.

The Director of Dietary Services and the Director of Care both confirmed the home's expectation was that staff comply with the policy.[s. 8. (1) (b)]

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 staff comply with the policy regarding weights being taken monthly, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Observation of Resident #03 and staff interviews revealed that two quarter bed rails were used when the resident was in bed.

A clinical record review revealed no evidence of a bed system evaluation or assessment to minimize the risk to the resident.

This was confirmed with the registered staff member, who also confirmed that the home's expectation was that where bed rails were used, the resident would be assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident-staff communication and response system could be easily accessed and used by all residents at all times.

On an identified date, Resident #03 was observed sitting in his/her wheelchair. The call bell was on the floor and not within reach of the resident.
A PSW confirmed the observation and acknowledged that the call bell should have been within reach of the resident.

The Acting Administrator indicated the expectation was that the call bell should have been accessible and within reach of the resident. [s. 17. (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 the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee was aware of, or that was reported to the licensee, was immediately investigated.

A review of CI 3047-000019-15 and an internal investigation report revealed that the home was made aware of two incidents of alleged abuse on a specified date. Documentation in the internal investigation indicates that investigation into the alleged abuse did not occur until eleven days after the incident.

The Director of Quality Improvement confirmed the investigation did not occur immediately, and the home's expectation was that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew, or that was reported to the licensee, was immediately investigated. [s. 23. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every alleged, suspected or witnessed incident of abuse or neglect of a resident is immediately investigated, to be implemented voluntarily.

WN #10: 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 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 shall immediately report the suspicion and the information upon which it was based to the Director.

A review of CI 3047-000019-15 completed for Residents #08 and #31 revealed that a family member for Resident #31 reported an allegation of abuse to the registered staff on an identified date. On the same date, family also reported their concern to another staff member.

A review of the internal investigation report revealed that the Administrator informed the Ministry of Health and Long Term Care two days following the incident.

An interview with the Director of Quality Improvement confirmed that the alleged abuse was not reported immediately to the Director and that the home's expectation was that any person who had reasonable grounds to suspect abuse of a resident would immediately report it to the Director. [s. 24. (1) 2.]

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 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 residents was immediately reported to the Director, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

A clinical record review for Resident #03 revealed that the resident was admitted on an identified date.
Further review of the clinical record revealed that the initial care conference was held during the 15th week post admission.

The Director of Quality Improvement confirmed the care conference was not held within six weeks of admission, and that it was the home's expectation that the care conference be completed within six weeks of admission. [s. 27. (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 a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written staffing plan for the nursing program and that the staffing plan included a backup plan for nursing staff that addressed situations when staff could not come to work.

A review of the backup plan for nursing staff revealed that there was no written backup staffing plan for registered staff that addressed situations when staff could not come to work including 24/7 RN coverage.

Interview with the Director of Quality Improvement confirmed that the home does not have a backup plan for nursing staff.

The Director of Quality Improvement confirmed that it was the home's expectation that the written staffing plan include a backup plan for nursing staff that addressed when staff could not come to work including 24/7 RN coverage. [s. 31.]

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 a back-up plan for staffing that addresses situations when staff, including the staff who must provide the registered nursing coverage cannot come to work, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

An interview with the Director of Quality Improvement revealed that there was no written documentation or evidence to support that a staff member involved in an alleged incident of abuse had completed training on prevention of abuse and neglect.

The Director of Quality Improvement also confirmed that it was the home's expectation that no staff would perform their responsibilities before receiving mandatory training in accordance with the legislation. [s. 76. (2) 3.]

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 no person performs their responsibilities before receiving training in the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council and Family Council was sought in developing and carrying out the satisfaction survey.

An interview with a member of Residents' Council and review of the Residents' Council minutes revealed that there was no documented evidence the home sought the advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

An interview with the Family Council President revealed that the home did not seek the advice of the Family Council when developing the satisfaction survey.

The Director of Recreation confirmed that the Family Council advice was not sought in developing the satisfaction survey.

The Administrator confirmed the expectation that the home should seek the advice of the Residents' Council and Family Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

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 the home seeks the advice of the Residents' Council and the Family Council in developing and carrying out the survey, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On an identified date, a housekeeping cart was observed outside a resident's room, unlocked and unattended with hazardous chemicals in the cart and accessible to residents.

A staff member confirmed that the housekeeping cart was unlocked and unattended.

The Director of Facility Services confirmed the expectation that all hazardous chemicals at the home should be kept inaccessible to residents at all times. [s. 91.]

2. On an identified date, a room was observed open and unattended with a resident in the room.
A hazardous chemical was observed in the unlocked cupboard.

The Director of Recreation confirmed the observation.

On a subsequent date, the identified room was again observed open and unattended with a resident in the room.
A hazardous chemical was observed in the unlocked cupboard.
A staff member confirmed that the resident had been left unattended in the room.

The Acting Administrator indicated that the expectation was residents should not be left unattended in the identified room and hazardous chemicals should not be accessible to residents. [s. 91.]

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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the Infection prevention and control program had an interdisciplinary team that coordinated and implemented the program and met at least quarterly.

Record review revealed there was no documented evidence of Infection prevention and control committee meeting minutes.

In an interview with the Director of Quality Improvement/Infection prevention and control Lead, it was confirmed that there were no other team members on the committee and there have been no meetings regarding the program since the home opened in August 2014. [s. 229. (2) (b)]

2. The licensee has failed to ensure that staff participate in the implementation of the Infection prevention and control program.

Observations of the following potential infection control risks were noted in identified residents shared bathrooms, bedrooms and tub room:

a) several unlabelled and improperly stored personal care items including urinals, wash basin, denture cup, toothbrushes, body lotion, deodorant, mouthwash and hair brushes.

b) visibly soiled and improperly stored toothbrushes and emesis basins in two shared bathrooms.

Observations were confirmed by three PSW's.

In an interview, the Director of Quality Improvement confirmed the expectation that

personal care items be labelled and kept clean and sanitary. [s. 229. (4)]

3. Medication observation on an identified date, revealed that the registered staff did not wash or clean his/her hands between administering medications to other residents.

The registered staff confirmed hand hygiene was not done between residents and indicated that it was the home's expectation that staff perform hand hygiene before and after caring for residents.

In an interview, the Director of Quality Improvement confirmed the home's expectation that all staff participate in the implementation of the Infection prevention and control program. [s. 229. (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 interdisciplinary team that co-ordinates and implements the program meets at least quarterly and that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 5th day of June, 2015

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

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 performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RAE MARTIN (515), ALI NASSER (523), DONNA TIERNEY (569), RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2015_416515_0013
Log No. / Registre no:	L-001936-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 20, 2015
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 :	Paula Thomson

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. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Order / Ordre :

The licensee must take action to achieve compliance by:

a) ensuring that data is entered into the review system to enable monitoring, analysis and evaluation of the data for quality improvements.

b) ensuring interdisciplinary representation on the Quality Improvement Committee and an interdisciplinary system to communicate changes made to the accommodation, care, services, programs, and goods provided to the residents.

c) ensuring ongoing communication of the quality improvements is provided to all residents, families and all staff of the home.

Grounds / Motifs :

1. The licensee has failed to implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

A review of the Quality Improvement and Required Programs LTCH Licensee Confirmation Checklist completed by the Administrator and dated April 30, 2015, revealed the Quality Improvement review system has not been implemented in the home.

The Director of Quality Improvement confirmed that data has not been entered into the review system to enable monitoring, analysis and evaluation of the information for quality improvement. The Director also confirmed there is no direct care staff member representation on the Quality Improvement Committee at this time.

The Director of Recreation confirmed there have been no meetings held of the Quality Improvement Committee.

The Administrator confirmed the expectation that the home implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.
(515)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 21, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Order / Ordre :

The licensee must take action to achieve compliance by:

a) ensuring there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

b) the policy is communicated to staff who have responsibility for monitoring the doors.

Grounds / Motifs :

1. The licensee has failed to ensure there was a written policy that dealt with doors leading to secure outside areas to permit or restrict unsupervised access to those areas by residents.

Observations made of the second, third and fourth floor balcony doors on three identified dates, revealed that the doors leading to the balconies were unlocked and unsupervised during the day. Residents were observed to be out on those balconies unsupervised.

On May 5, 2015, the Director of Quality Improvement confirmed that the door to the fourth floor balcony was unlocked and unattended and also confirmed that the home does not have a written policy regarding doors leading to secure outside areas. (515)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2015

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rae Martin

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