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
Jun 26, 2015	2015_229213_0022	012241-15	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

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

This inspection was conducted on the following date(s): June 19, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Consultant, a Registered Practical Nurse, a Behavioural Support Staff, a Personal Support Worker, three Residents and a Family Member.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every Resident has the right not to be neglected by the licensee or staff.

Record review revealed an incident of Resident to Resident aggression occurred on a specified date when Resident #101 entered the room of Resident #100.

Interview with Resident #100 revealed that they are afraid of Resident #101, and now keeps the door closed all of the time. Resident #100 indicated that they are lonely in the room with the door closed all the time. Resident #100 also indicated that no one from the home has spoken to them or followed up with them regarding the incident that occurred.

Staff interview with a Personal Support Worker and a Registered Practical Nurse revealed that Resident #100 has voiced that they are afraid of Resident #101.

Record review revealed no documentation regarding the assessment of Resident #100 was found related to the incident.

Record review of progress notes for Resident #100 revealed that on a particular date, this Resident approached the staff in the hallway asking if they are doing anything about the Resident and the incident.

No changes were made to the care plan of Resident #100 until the day after the family had voiced a complaint, three weeks after the incident.

Staff interview with the Administrator and the Director of Care confirmed that Resident #100 was not provided with the treatment, care, services or assistance required for health, safety or well-being following the incident that occurred on May 21, 2015. [s. 3. (1) 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 the following rights of residents are fully respected and promoted: Every resident has the right not to be neglected by the licensee or staff, to be implemented voluntarily.

WN #2: 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. (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 care set out in the plan of care was provided to the resident as specified in the plan.

Record review of the plan of care and Kardex for Resident #100 revealed a particular intervention was to be in place.

Observations on two occasions during the inspection revealed the intervention was not in place

Interview with the Administrator and the Director of Care confirmed the expectation that the care is to be provided as per the care 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 that the care set out in the plan of care is provided to the Resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 a person who had reasonable grounds to suspect that any of the following has occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director: 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.

Record review revealed an incident of Resident to Resident aggression occurred on a specified date when Resident #101 entered the room of Resident #100.

Interview with Resident #100 revealed that they are afraid of Resident #101, now keeps the door closed all of the time, and feels lonely in the room with the door closed all of the time.

Staff interview with the Director of Care and the Administrator confirmed that they were aware of the incident with Resident #100 and #101. They confirmed that Resident #100 suffered emotional abuse as they are afraid of Resident #101 and that there is risk due to the dementia of Resident #101. They also confirmed that a Critical Incident was not reported as Resident #100 suffered no physical injury. [s. 24. (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 that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director: 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, to be implemented voluntarily.

Issued on this 26th day of June, 2015

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

Original report signed by the inspector.