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
Jan 4, 2016	2015_303563_0055	012005-15	Critical Incident System

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

MELANIE NORTHEY (563), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

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

The following Critical Incident Inspections were completed concurrently:
3047-000024-15 / Log # 012005-15 related to improper treatment of a resident
3047-000029-15 / Log # 019310-15 related to improper treatment of a resident
3047-000030-15 / Log # 025869-15 related to suspected staff to resident abuse
3047-000031-15 / Log # 033981-15 related to a missing resident for less than 3 hours
3047-000032-15 / Log # 025869-15 related to suspected staff to resident abuse
3047-000033-15 / Log # 026386-15 related to a missing resident for less than 3 hours
3047-000035-15 / Log # 028905-15 related to an unexpected death
3047-000040-15 / Log # 029528-15 related to personal care

PLEASE NOTE: A Written Notification (WN #1) and Compliance Order #001 under O. Reg 79/10, s. 101, identified in this inspection (Log #012005-15) will be issued under a Follow Up Inspection # 2015_226192_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 Licensee, the Resident Assessment Instrument Coordinator, the Geriatric Clinical Nursing Specialist, three Registered Practical Nurses, four Personal Support Workers and eight residents.

The inspector(s) also made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

10 WN(s)
7 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.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home have received training as required by this section.

Staff interview with the Administrator, the acting Director of Care (DOC), and the Geriatric Clinical Nurse Specialist on December 9, 2015 confirmed that they had no records of education completed in 2015 as no mandatory training or education was completed by any staff in 2015 including: the Residents' Bill of Rights, the home's mission statement, the policy to promote zero tolerance of abuse and neglect of residents, mandatory reporting, whistle blower protection, the policy to minimize the restraining of residents, fire prevention and safety, emergency evacuation procedures, infection prevention and control, mental health, behaviour management, palliative care, prevention of falls, skin and wound care, pain management, or continence. [s. 76. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
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 residents' right to 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, were fully respected and promoted.

Observations revealed there was a chart rack in the first floor nursing station that is approximately 20 feet from the main entrance to the building. The chart rack was against the wall beside the nursing station desk with no door to the nursing station. The chart rack was observed to be on wheels, not locked with residents' names and room numbers visible. The privacy and locking mechanism on the rack was broken and sitting on the top of the rack with two charts also sitting on top of the rack. Resident charts with personal health information were not kept confidential.

Observations from approximately 1100 to 1300 hours revealed this same chart was unattended by staff for a period of over 30 minutes with resident charts accessible.

Staff interview with the Administrator, the acting Director of care (DOC), and the Geriatric Clinical Nurse Specialist on December 9, 2015 confirmed the home's expectation was that in order to safeguard the privacy of residents' personal health information, the chart racks were to be kept locked in the therapy rooms to ensure that they were not accessible to anyone but staff when unattended. [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 that the residents' right 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, were fully respected and promoted, to be implemented voluntarily.

WN #3: 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. (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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident and the goals the care was intended to achieve.

Record review of the quarterly "Head to Toe Assessment" revealed resident # 002 used dentures.

Record review of the Minimum Data Set (MDS) Assessments revealed resident # 002 had dentures since admission.

Record review of the Point of Care (POC) kardex revealed the "Dental Care" focus only instructed Personal Support Workers (PSWs) to "Provide oral hygiene." There was no mention that the resident used dentures, received routine denture care or was assisted with the application/removal of the dentures.

Record review of the current care plan revealed the focus related to oral care did not document the planned care related to the use of dentures or the goals the denture care was intended to achieve.

Staff interview with the Administrator confirmed the denture used by resident # 002 should have been a part of the plan of care and confirmed the current care plan did not set out the planned care related to the use of dentures and the goals the denture care was intended to achieve.

Staff interview with the acting DOC confirmed denture care was not a part of resident # 002's plan of care. [s. 6. (1)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to transfers and toileting.

Record review of the Critical Incident Report # 3047-000040-15 revealed resident # 003 was transferred multiple times without a second Personal Support Worker (PSW) to assist.

Record review of current care plan revealed the transfer focus had interventions where resident # 003 required physical assistance with two staff.

Record review of the kardex revealed the toileting focus and interventions for PSWs stated staff will provide transfer assistance as needed. The kardex did not provide direction related to transferring resident # 003 from one position to another.

Observation of resident # 003 revealed a transfer logo in the resident's room indicated the resident was to be transferred by two people. Interview with resident # 003 at this time confirmed he/she was aware that he/she required two staff to transfer at all times.

Staff interview with the Administrator confirmed the kardex was the point of reference for PSWs and confirmed the resident's plan of care did not provide clear direction to staff who provide direct care related to transfers and toileting. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to mobility.

Record review of current care plan on December 8, 2015 revealed the locomotion focus had an intervention where resident # 004 was identified as being independent. Review of the mobility focus revealed the resident required supervision with one staff support for locomotion on and off the unit and for walking on and off the unit.

Record review of the Outcome Scores generated by the Quarterly MDS Assessment revealed the resident had a Cognitive Performance Scale of four out of six, demonstrating moderate to severe cognitive impairment.

Staff interview with the Registered Practical Nurse (RPN) on second floor confirmed

resident # 004 requires supervision and at times physical assistance depending on the day.

Staff interview with the Acting Director of Care (DOC) confirmed the plan of care did not set out clear directions to staff and others who provide direct care to the resident related to staff supervision of resident # 004's mobility and walking on and off the unit. [s. 6. (1) (c)]

4. 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 Critical Incident Report # 3047-000031-15 and progress notes for resident # 105 revealed this resident exited the building after a registered staff member signed him/her out. Another registered staff member was informed of this resident leaving the building unassisted and reported the resident missing. The resident was found unharmed and returned to the home.

Record review of the plan of care for resident # 105 revealed the following:
- Wandering behaviours
- Resident will be able to attend outside activities with supervision assistance to ensure safety
- Registered staff and Recreational Staff are to schedule resident's desired outings and ensure supervision is arranged

Staff interview with the Administrator and the acting DOC confirmed that the plan of care for resident # 105 indicated that this resident should not have been allowed to leave the building unassisted. They confirmed that a registered staff member allowed the resident to leave the building unassisted. They also confirmed the home's expectations that care was to be provided as per the plan of care. [s. 6. (7)]

5. 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.

Observations revealed resident # 102 was lying on top of his/her made bed partially dressed with brief exposed. There was a strong odor of urine in the room. The resident's breakfast was observed to be sitting untouched and cold on the over-bed table at the side of the bed.

Record review of the current plan of care for resident # 102 revealed this resident required supervision for eating, physical assistance for transferring, personal hygiene, and toileting.

The RPN confirmed that this resident requires assistance for grooming, dressing, toileting and was disoriented related to eating as he could not go to the dining room for the meal. The RPN confirmed the expectation that staff should have monitored this resident at a minimum of every two hours and provided assistance with hygiene and toileting. The RPN confirmed the expectation that this resident should have been monitored during the meal and provided assistance with the meal to ensure that the meal was consumed.

Interview with the Administrator and the acting Director of Care confirmed the home's expectation was that this resident should have been monitored at a minimum of every two hours and provided assistance with hygiene, toileting and eating prior to 1050 hours. [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 there was a written plan of care for each resident that set out the planned care for the resident and the goals the care is intended to achieve and to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: 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 appropriate action was taken in response to every such incident regarding abuse or neglect of a resident.

Record review of the Critical Incident Report # 3047-000032-15 revealed resident # 001 displayed socially inappropriate behaviours and a Personal Support Worker (PSW) was witnessed speaking to the resident "in a loud tone of voice."

Staff interview with the Administrator confirmed appropriate action was not taken in response to Critical Incident # 3047-000032-15. The Administrator confirmed the PSW did not receive the Gentle Persuasion Approach (GPA) and non-abuse retraining prior to her returning to work as stated would happen in the critical incident report. [s. 23. (1) (b)]

2. Record review of the Critical Incident Report # 3047-000040-15 revealed resident # 003 was transferred multiple times without a second Personal Support Worker (PSW) to assist.

Staff interview with the Administrator confirmed appropriate action was not taken in response to Critical Incident # 3047-000040-15. The Administrator confirmed the PSW was to return to work once education related to non-abuse training and safe lifts and transfer training was completed. The PSW was called in for a shift and worked and still had not received the appropriate planned education prior to returning to work. The Administrator shared that the PSW worked four shifts before the Administrator realized

the PSW had returned without retraining.

The PSW neglected to transfer the resident as planned with two staff at all times, putting the resident at risk for a potential fall with a potential injury. [s. 23. (1) (b)]

3. Record review of the Critical Incident Report # 3047-000030-15 and the home's internal investigation records revealed resident # 104 reported to a Registered Practical Nurse (RPN) during the night shift that he/she felt a Registered Nurse (RN) was sexually inappropriate with him/her. The RPN advised the RN involved in the incident and the RN reported the incident to management at the end of the night shift.

The home indicated in the "Analysis and follow up" section of the critical incident report that "Registered staff will need to be re-educated on the importance of reporting all instances of abuse to the proper authorities" and "that they have not re-educated staff regarding reporting abuse."

Staff interview with the Administrator confirmed that they have not re-educated any staff on reporting of abuse in 2015 as they indicated in the critical incident and all appropriate actions were not taken. [s. 23. (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 that appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering, and any potential behavioural triggers and variations in resident functioning at different times of the day.

Record review of Critical Incident Report # 3047-000031-15 and progress notes for resident # 105 revealed this resident exited the building after a registered staff member signed the resident out. Another registered staff member was informed of this resident leaving the building unassisted and reported the resident missing. The resident was found unharmed and returned to the home. The "Analysis and Follow up" reported in the critical incident report indicated, "We would like to do an MMSE (Mini Mental State Examination) and or MOCA (Montreal Cognitive Assessment) to determine if the resident is capable of leaving the building on their own. We will ask the attending medical doctor (MD) to order this and if the resident is deemed unsafe to leave the building, we will place a roam alert bracelet on so that staff will know if he/she is attempting to exit the building".

Record review of the plan of care for resident # 105 revealed:
- Wandering behaviours
- Resident will be able to attend outside activities with supervision assistance to ensure safety
- Registered staff and Recreational Staff are to schedule resident's desired outings and ensure supervision is arranged

Record review of the assessments completed for resident # 105 revealed no MMSE or MOCA was completed. Record review of physician's orders for this resident revealed no orders for an MMSE or MOCA or indication that the resident cannot leave the building unassisted.

Staff interview with the Administrator and the acting Director of Care confirmed that the plan of care for resident # 105 was not based on an interdisciplinary assessment of this resident's mood and behaviour patterns including wandering. They confirmed that an assessment was not completed related to this resident's ability to leave the building unassisted. They also confirmed the expectation of the home was that plans of care for residents were based on an interdisciplinary assessment and that resident # 105 should have been assessed related to his/her ability to leave the building safely without assistance. [s. 26. (3) 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 responsive behaviour plan of care based on an interdisciplinary assessment of the resident that includes: any mood and behaviour patterns, including wandering: any identified responsive behaviours; any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #6: 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 breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review of Critical Incident Report # 3047-000029-15 and progress notes for resident # 103 revealed this resident suffered a skin tear. Record review of the health record for resident # 103 revealed an initial skin tear assessment was completed however no skin tear assessments were found following the initial assessment.

Record review of the home's "Skin and Wound Care Program Implementation CPM-F-20" revealed, "Wound Assessment Initial/Ongoing - will be completed by Registered Staff at a minimum of once weekly. The initial and ongoing wound assessment is implemented when a resident has any open area involving the dermal layer and deeper (including surgical wounds), skin tears will be assessed using the skin tear(s) assessment (initial and ongoing). One assessment is completed per wound. Skin tear assessment allows for multiple skin tears to be recorded per incident. The treatment regimen is also recorded on the treatment administration record (TAR)."

An interview with the Administrator and the acting Director of Care confirmed the home's expectation that skin tear assessments should have been completed weekly following the initial assessment until the skin tear was healed. They confirmed that only the initial skin tear assessment was completed and no weekly skin tear assessments were completed as required. [s. 50. (2) (b) (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 that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

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 failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to those behaviours, where possible.

Record review of the Critical Incident Report # 3047-000032-15 dated September 12, 2015 revealed resident # 001 had inappropriate behaviours.

Record review of the MDS Assessments revealed resident # 001 had displayed socially inappropriate / disruptive behavioural symptoms almost daily since admission and the behaviour was not always easily altered.

Record review of the progress notes revealed the inappropriate behaviour was first documented several months ago. There were twenty-seven documented progress notes detailing the resident's inappropriate behaviour in a six month period of time.

Record review of the home's investigation notes revealed an interview took place between resident # 001 and the Director of Care (DOC) where by it was documented that the resident was to now have specific interventions in place to address the inappropriate behaviour.

Record review of current care plan revealed there were no strategies developed and implemented to respond to the inappropriate behaviour of resident # 001.

Staff interviews with two Personal Support Workers (PSWs) revealed resident # 001 had

socially inappropriate behaviours.

Staff interview with the Administrator confirmed the socially inappropriate behaviour should be care planned and the specific interventions mentioned in the home's investigation notes and in the progress notes should be a strategy implemented and documented in the care plan to respond to these behaviours. [s. 53. (4) (b)]

2. Record review of the Critical Incident Report # 3047-000033-15 revealed resident # 004 was missing less than three hours.

Record review of a “Behaviour” progress note revealed staff working on this resident's floor were unable to locate resident. Staff searched floor and then entire building and grounds surrounding building. Staff eventually found resident in the home.

Record review of the Minimum Data Assessment (MDS) Assessments revealed resident # 004 had behavioural symptoms documented on two different MDS Assessments where by the resident displayed wandering behaviours occurring up to three days within the MDS assessment period. The MDS Assessments documented that this behaviour was easily altered.

Record review of the Point of Care (POC) kardex revealed there were no wandering behaviour interventions documented for PSWs.

Record review of the current care plan revealed the focus related to “Locomotion” and “Walking” required staff supervision. Review of the care plan also revealed there were no strategies developed and implemented to respond to the wandering behaviours of resident # 004.

Staff interview with the acting Director of Care confirmed wandering behaviour was not a part of resident # 004’s care plan and strategies were not developed or implemented to respond to these behaviours in the current care plan. [s. 53. (4) (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 that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to those behaviours, where possible, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who requires assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Observations revealed resident # 102 was lying on top of his/her made bed partially dressed with brief exposed. The resident's breakfast was observed to be sitting untouched and cold on the over-bed table at the side of the bed.

Staff interview with a Registered Practical Nurse (RPN) revealed that resident #102 was in his/her room. The RPN confirmed the expectation that this resident should have been monitored during the meal and provided physical assistance with the meal when it was served.

An interview with the Administrator and the acting Director of Care confirmed the home's expectation was that this resident should have been monitored and provided assistance with his meal when his breakfast was served in his room. [s. 73. (2) (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 that) no resident who requires assistance with eating or drinking is served a meal until someone was available to provide the assistance required by the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of the Critical Incident Report # 3047-000030-15 and the home's internal investigation records revealed resident # 104 reported to a Registered Practical Nurse (RPN) during the night shift that he/she felt a Registered Nurse (RN) was sexually inappropriate with him/her. The RPN advised the RN involved in the incident and the RN reported the incident to management at the end of the night shift.

Record review of the home's policy "Resident Non-Abuse" HR-K-30 revealed "All staff are expected to fulfill their legal obligations to report any incident or suspected incident of resident abuse or neglect. In any case of abuse or suspected abuse, the employee or any other person witnessing or having knowledge of an incident shall, verbally, report the incident immediately to their department head or immediate supervisor, or, during the evening and night hours, to the most senior supervisor available."

Staff interview with the Administrator confirmed that this complaint was not documented on a Client Services Response (CSR) form and that the RPN and the RN did not immediately report the allegation of abuse as per the policy. [s. 20. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of an incident, or sooner if required by the Director, make a report in writing to the Director setting out a description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident.

Record review of Critical Incident Report # 3047-000024-15 related to an allegation of improper or incompetent treatment of a resident that results in harm or risk to a resident revealed the home did not identify the name of the staff member accused in the incident.

An interview with the Administrator confirmed the expectation that all staff involved in an incident should have been identified in the Critical Incident # 3047-000024-15. [s. 107. (4) 2. ii.]

Issued on this 14th day of January, 2016

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) :	MELANIE NORTHEY (563), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2015_303563_0055
Log No. / Registre no:	012005-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 4, 2016
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. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that 100% of staff complete all mandatory education as per LTCHA 2007, c.8, s.76.

The plan shall include the following:
a) Time lines for the completion of the education of 100% of staff as per LTCHA 2007, c.8, s.76. (1) (including all staff absent on the day of education). All education must be completed by March 31, 2016.
b) A description of the method of and contents of education to be completed.
c) Who is responsible for the management of this education in the home including completion, monitoring and follow up.

Please submit the plan, in writing, to Melanie Northey, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email to melanie.northey@ontario.ca by by January 29, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff at the home have received training as required by this section.

Staff interview with the Administrator, the acting Director of Care (DOC), and the Geriatric Clinical Nurse Specialist on December 9, 2015 confirmed that they had no records of education completed in 2015 as no mandatory training or education was completed by any staff in 2015 including: the Residents' Bill of Rights, the home's mission statement, the policy to promote zero tolerance of abuse and neglect of residents, mandatory reporting, whistle blower protection, the policy to minimize the restraining of residents, fire prevention and safety, emergency evacuation procedures, infection prevention and control, mental health, behaviour management, palliative care, prevention of falls, skin and wound care, pain management, or continence. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

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 4th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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