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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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_0054	010431-15	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

MELANIE NORTHEY (563)

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): December 7, 8 and 9, 2015

This complaint inspection was related to personal care issues, dignity lacking, allegations of verbal abuse and reporting and complaints.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, Director of Dietary Services, two Dietary Aides, one Registered Practical Nurses, two Personal Support Workers, one family member and one Resident.

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 the identified resident were reviewed.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Food Quality
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. 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 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 is based to the Director.

Record review of a written complaint from resident # 007 family member revealed allegations of verbal abuse by a Personal Support Worker (PSW).

Interview with resident # 007 revealed a PSW yelled at the resident in the dining room.

Record review of the response letter written by the Administrator to resident # 007's family member / POA revealed, "I would like to apologize profusely for the behaviour of the staff at Earls Court Village (ECV) and at no time wish the resident to ever feel this way again. What happened was unacceptable. Abuse in any form is not tolerated at ECV."

Record review of the Ministry of Health and Long Term Care Portal for critical incident reporting revealed there was no submitted critical incident related to the alleged verbal abuse of resident # 007 and the Administrator confirmed that the home did not immediately investigate the alleged incident that was reported. The home failed to report the suspicion of abuse immediately to the Director. [s. 24. (1) 2.]

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

Record review of a written complaint from a family member / Power of Attorney (POA) of resident # 007 revealed an appliance was requested in order to protect a specialized garment from being ruined. The written complaint also documented that the resident's identification (ID) bracelet did not have the resident's correct name.

Record review of the current care plan for resident # 007 revealed sections where the resident's wrong name was documented.

Telephone interview with the family member, POA, revealed staff will still refer to the resident by her middle name when speaking to the family member.

Interview with resident # 007 confirmed the legal birth name on the birth certificate did not match the name on the ID bracelet and at times staff would refer to the resident by the resident's middle name.

Record review of the "Multidisciplinary Care Conference (Initial & Annual) SVCH 2014"

revealed there was a discussion related to the appliance that was to be provided in order to protect a specialized garment from being ruined.

Telephone interview with the family member, POA, revealed that the appliance has still not been provided for the resident to hang and dry the specialized garment over night.

Interview with resident # 007 confirmed he/she did not feel as though he/she was being treated with respect and dignity.

Observation of the Administrator's office revealed an appliance had been ordered and was stored in the office. Staff interview with the Administrator at this time revealed it has been in her office for "a while" and confirmed the resident has not seen the appliance and there has not been any follow up with the resident or her family member.

The home did not promote the resident's right to be treated with respect. Staff were not using the resident's correct name, did not update her ID bracelet for eight months and did not provide the resident with an appliance despite being asked a number times in an eleven month period. [s. 3. (1) 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 the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity is 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Record review of the "Multidisciplinary Care Conference (Initial & Annual) SVCH 2014" revealed resident # 007 and the resident's family member and Power of Attorney (POA) attended. The "concerns / suggestions" discussed included the POA not being informed when there was a change in medications or treatments.

Record review of the progress notes revealed a specific medication was discontinued and other medication was ordered as needed without the POA's knowledge. The POA was updated after they noticed a change in the resident and not at the time of the change as discussed in the care conference.

Telephone interview with the family member, POA, of resident # 007 revealed the home does not notify the POA when changes were made to pain medications and other treatments. The POA confirmed notification of medication changes was not a consistent practice by staff.

Staff interview with the Administrator confirmed nursing staff have been educated regarding the appropriate notification of family when a medication or treatment plan has changed; however she also confirmed this has been an ongoing issue where the family had not been provided the opportunity to participate fully in the development and implementation of the plan of care for resident # 007. [s. 6. (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 resident, the SDM, if any, and the designate of the resident / SDM is provided the opportunity to participate fully in the development and implementation of the plan of care, 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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported was immediately investigated.

Record review of a written complaint from resident # 007 family member revealed allegations of verbal abuse by a Personal Support Worker (PSW).

Telephone interview with the family member, POA, of resident # 007 shared that there was no follow up with the resident or the POA related to a PSW who yelled at the resident earlier this year.

Interview with resident # 007 shared that a PSW yelled at the resident in the dining room.

Record review of the response letter and written by the Administrator to resident # 007's family member / POA revealed, "I would like to apologize profusely for the behaviour of the staff at Earls Court Village (ECV) and at no time wish the resident to ever feel this way again. What happened was unacceptable. Abuse in any form is not tolerated at ECV."

Record review of the Ministry of Health and Long Term Care Portal for critical incident reporting on December 8, 2015 revealed there was no submitted critical incident related to the alleged verbal abuse of resident # 007 and the Administrator confirmed that the home did not immediately investigate the alleged incident that was reported. [s. 23. (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 every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated: abuse of a resident by anyone, 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's special treatments and interventions.

Telephone interview with the family member, POA, revealed that resident # 007 used a specialized garment.

Staff interview with a PSW confirmed the resident does use a specialized garment and requires extensive assistance for it's use.

Interview with resident # 007 revealed the resident requires one staff to assist in applying the specialized garment. Observation of resident # 007 confirmed the resident wears a specialized garment.

Record review of the current care plan revealed there were no goals or interventions related to the use of a specialized garment.

Staff interview with the Acting Director of Care on December 9, 2015 confirmed the plan of care was not based on an interdisciplinary assessment of the resident's special treatments and interventions related to the use of a specialized garment. [s. 26. (3) 18.]

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Telephone interview with the family member, Power of Attorney, shared that resident # 007 has a specific time the resident prefers to rise in the morning and on at least 5 different occasions the resident rang the call bell only to wait 25-60 minutes before someone attended to the resident's needs. Interview with resident # 007 confirmed this.

Record review of the current care plan revealed there were no goals or interventions related to the resident's sleep patterns and preferences.

Staff interview with a PSW confirmed the resident's preferences related to sleep and rest routines.

Staff interview with the Acting Director of Care confirmed the plan of care was not based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

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

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Issued on this 12th 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)
Inspection No. / No de l'inspection :	2015_303563_0054
Log No. / Registre no:	010431-15
Type of Inspection / Genre d'inspection:	Complaint
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:

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

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. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee must ensure that any allegations or suspicions of abuse of a resident by anyone is reported immediately to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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 is based to the Director.

Record review of a written complaint from resident # 007 family member revealed allegations of verbal abuse by a Personal Support Worker (PSW).

Interview with resident # 007 revealed a PSW yelled at the resident in the dining room.

Record review of the response letter written by the Administrator to resident # 007's family member / POA revealed, "I would like to apologize profusely for the behaviour of the staff at Earls Court Village (ECV) and at no time wish the resident to ever feel this way again. What happened was unacceptable. Abuse in any form is not tolerated at ECV."

Record review of the Ministry of Health and Long Term Care Portal for critical incident reporting revealed there was no submitted critical incident related to the alleged verbal abuse of resident # 007 and the Administrator confirmed that the home did not immediately investigate the alleged incident that was reported. The home failed to report the suspicion of abuse immediately to the Director.

The severity is determined to be a level 2 as there was a potential for actual harm to this resident. The scope of this issue is isolated to this one resident during the course of this inspection, however there is a compliance history of this regulation being issued in the home on January 27, 2015, April 28, 2015 during the RQI inspection and on June 19, 2015. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 04, 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