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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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 11, 2016	2016_303563_0012	009805-16	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): April 13 - 15 and 20 -21, 2016

PLEASE NOTE:
A Written Notification (WN #2) and Compliance Order #002 under O. Reg 79/10 s. 6 (1)(c)
A Written Notification (WN #2) and Compliance Order #003 under O. Reg 79/10 s. 6 (2)
A Written Notification (WN #2) and Compliance Order #004 under O. Reg 79/10 s. 6 (7)
A Written Notification (WN #3) and Compliance Order #005 under O. Reg 79/10 s. 3(1)(4)
identified in this inspection (Log # 009805-16) will be issued under a Follow Up Inspection # 2016_229213_0013 / Log #008403-16 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Acting Director of Care, the President & Chief Executive Officer, the Assistant Director of Care, the Resident Assessment Instrument Coordinator, the Director of Care, one Registered Practical Nurse, three family members and four Personal Support Workers.

The inspector also made observations of the resident and care provided. Relevant policies and procedures, as well as clinical records and plan of care for the identified resident was reviewed.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

2 WN(s)
2 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:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to respect or promote the resident's right to be told who was responsible for their care.

Staff interview with the President and Chief Executive Operator confirmed the home has a new acting Dietary Manager, a new Resident Assessment Coordinator (RAI-C), a new Director of Recreation (DOR), a new Administrator and a new Director of Care (DOC). He also confirmed only Family and Resident Council were made aware of the interim management team and confirmed that not all residents and family were told that there was a new interim and permanent management team in place.

Observations by inspector #213 revealed the residents and family council meeting minutes were absent from the board at the front entrance where all the required postings were located. The meeting minutes were also absent from all home care areas. Therefore, anything discussed at the Resident and Family Councils related to the new management team would not have been communicated to any other resident or family member who did not attend the meetings.

Staff interview with the acting Administrator # 101 by inspector # 213 revealed the acting Administrator attended the Residents Council and Family Council meetings in February 2016 to let residents and families know that her and the acting DOC were in the home helping the management team. The acting Administrator was unaware if there was a written communication for all residents and families. The acting Administrator shared that the new Director of Recreation (DOR) was currently working on a newsletter for residents and families to advise them of the new Administrator, the new DOC and the new DOR.

Record review of the Complaint Information Report # IL-43893-LO submitted to the

Ministry of Health revealed the complainant walked in on the DOC speaking to another DOC from another LTC home regarding the residents care, and felt this was a breach of confidentiality.

Telephone interview with a family member of resident # 007 revealed the home did not provide the resident or the family members with information regarding the new interim management team at Earls Court Village (ECV). The family member shared that she submitted a complaint to the Ministry of Health (MOH) and discussed her concerns about confidentiality at the Multidisciplinary Care Conference.

Interview with other family members of resident # 007 shared that the communication in the home between staff and between staff and the family was poor and also confirmed the home did not tell the resident or the family who was now responsible for the resident in terms of the new management team temporarily in place.

Staff interview with Registered Nurse (RN) # 113 on by inspector #213 revealed there was a general staff meeting introducing the new Administrator and DOC and a memo to staff to announce the new management staff. The RN was unaware if any information had gone out to residents and families regarding the acting Administrator and acting DOC or about the new permanent Administrator and permanent DOC starting.

During a conversation with physician # 133, inspector # 213 shared that the new Administrator and DOC started on Monday April 18, 2016 and the physician shared that he/she knew some management staff were outgoing, but did not know new staff were starting.

The licensee has failed to fully respect and promote the residents' right to be told who was responsible for his or her care and this caused confidentiality concerns for the family of resident # 007. [s. 3. (1) 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 the resident's right to be told who is responsible for their care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written record was kept up to date at all times.

Interview with family members of resident # 007 revealed the Power of Attorney (POA) for personal care had changed and confirmed the change in POA documentation was given to the home last week and questioned if the information was updated in the resident's chart.

Record review of the resident "Profile" tab in PointClickCare (PCC) revealed only specific people were the "POAs for Care".

Record review of the "Power of Attorney for Personal Care (& Living Will) for resident # 007 revealed there were other people listed to act as attorneys (individually and collectively)" for this resident.

Staff interview with the Director of Care # 117 confirmed the POA information in the written record for resident # 007 was not up to date. [s. 231. (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 the resident's written record is kept up to date at all times, to be implemented voluntarily.

Issued on this 12th day of May, 2016

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

Original report signed by the inspector.