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 soins 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
Jul 8, 2016	2016_303563_0017	017346-16	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), NATALIE MORONEY (610), 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): June 13-17 and 21, 2016

The following inspections were conducted concurrently during the Critical Incident (CI) inspection # 2016_303563_0017 / log # 017346-16:
CI # 3047-000003-14 / Log # 014485-16 related to suspected resident abuse
CI # 3047-000011-16 / Log # 012427-16 related to suspected resident neglect
CI # 3047-000013-16 / Log # 012715-16 related to a fall and fracture
CI # 3047-000014-16 / Log # 013309-16 related to missing medications

CI # 3047-000015-16 / Log # 013670-16 related to resident suspected neglect
CI # 3047-000017-16 / Log # 014485-16 related to suspected resident abuse
CI # 3047-000018-16 / Log # 014473-16 related to toileting plan
CI # 3047-000020-16 / Log # 014461-16 related to suspected resident neglect
CI # 3047-000027-16 / Log # 015454-16 related to dignity and respect
CI # 3047-000030-16 / Log # 015838-16 related to diet orders
CI # 3047-000031-16 / Log # 016063-16 related to dignity and choice
CI # 3047-000032-16 / Log # 016281-16 related to suspected resident neglect
CI # 3047-000033-16 / Log # 016474-16 related to pain management
CI # 3047-000043-16 / Log # 017206-16 related to suspected resident neglect
CI # 3047-000044-16 / Log # 017201-16 related to suspected resident abuse
CI # 3047-000047-16 / Log # 017346-16 related to responsive behaviours
CI # 3047-000050-16 / Log # 017929-16 related to suspected resident neglect
Anonymous Compliant IL-44551-LO / Log # 013383-16 related to suspected resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Registered Dietitian, the President & CEO, the Director of Dietary Services, one Physiotherapy Assistant, the Office Manager, the Resident Assessment Instrument Coordinator, the Pharmacist, the Receptionist, fourteen residents, ten Registered Practical Nurses, three Registered Nurses and twenty-four Personal Support Workers.

The inspector(s) also made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records, the home's investigation notes and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas and resident/staff interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

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

3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Progress notes in PointClickCare for resident #011 stated the resident was complaining of pain and was transferred to hospital with an injury. The resident returned to the home with an order for pain medication as needed. Several days later, the family of resident #011 reported that the resident was experiencing pain and requested the pain medication to be given as a regular scheduled dose.

Assessments completed in PointClickCare indicated that a pain assessment was completed for resident #011 five days after returning from hospital. The assessment said the resident reported pain.

The current plan of care for resident #011 was revised 20 days after returning from hospital, indicating pain and an increased level of assistance required related to the injury.

The home's "Pain Assessment and Symptom Management Implementation" policy #CPM-D-20 dated February 2012 stated "Each resident will be assessed by the registered staff upon admission, quarterly, annually, and with any identified alteration of the resident's pain processes."

The Director of Care #102 said that the expectation was that a pain assessment should have been completed and that the resident's plan of care should have been reviewed

and revised when resident #011 returned from hospital with an injury.

Resident #011 was not reassessed and the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Records review for resident #071 indicated three documented occasions where the resident was left for an unaccounted period of time during a toileting routine. Resident #071 stated they were left longer than they should have and said that it had not happened recently.

Records review of resident #071's care plan indicated that there was a scheduled toileting plan and required one staff physical assistance. This care plan did not indicate any use of a specific toileting appliance to meet resident #071's toileting needs.

Staff interview with Personal Support Worker (PSW) #122 and Registered Practical Nurse (RPN) #123 explained that resident #071 toileting routine and use of toileting appliance had changed. The RPN #123 said that the care plan was not updated for resident #071's toileting needs when they changed.

The Director of Care #102 stated in an interview that the home did not change resident #071's care plan when the toileting care needs changed. [s. 6. (10) (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 is reassessed and the plan of care reviewed and revised when the resident's care needs changed, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was be based on, at a minimum, interdisciplinary assessment of the following with respect to special treatments and interventions.

The record review in PointClickCare (PCC) and the critical incident submitted to the Ministry of Health documented that a family member of resident #031 reported to staff that a Registered Practical Nurse (RPN) did not assess the resident when the resident's health status changed and when a specific medical directive was not followed.

The three month medication review documented that the resident had a specific medical directive ordered.

The current electronic medication assessment record (eMar) stated that the specific medical directive was ordered as necessary (PRN) and to initiate this therapy as ordered and to notify the Medical Doctor and ask for further instructions if necessary.

The Personal Support Worker #127 said that the resident required this specific medical directive and that the nurse tells the PSW staff what measurement of therapy was to be delivered to the resident.

The RPN #129 said that the resident received this specific medical directive, they were not signing for the this specific therapy, there was no current assessment completed in the resident's chart or PCC, and that the current medical directive was not the current order in the eMar.

The Registered Respiratory Therapist (RRT) #126 said that there was no completed assessment with interventions for the use of this therapy for resident #031. The RRT also said that the current medical directive on the three month review had no interventions to monitor the resident's status or what measurement of therapy was to be delivered to the resident. That current eMar order was usually used if the resident had a specific medical

diagnosis which resident #031 does not have.

The Administrator #101 said it was the homes expectation that residents who require this specific therapy would have an assessment with interventions and monitoring and that the plan of care would set out clear direction to staff and they had not done the assessment and interventions for the treatment.The plan of care was to be based on, at a minimum, interdisciplinary assessment of the following with respect to the administration of this therapy. [s. 26. (3) 18.]

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident; special treatments and interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all 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. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident including the names of any staff members or other persons who were present at or discovered the incident.

Record review of the Critical Incident (CI) Report # 3047-000003-14 submitted to the Ministry of Health stated the names of the family members who were made aware of the incident and the name of the resident involved in the incident. The CI did not provide the name of the Personal Support Worker accused of abuse or the name of any staff members who were present during the time the alleged abuse occurred.

The Administrator said the CI submitted in 2014 did not name any of the staff members who were present at or discovered the incident. [s. 104. (1) 2.]

Issued on this 8th day of July, 2016

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

Original report signed by the inspector.