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 11, 2017	2017_263524_0015	012217-16, 016471-16, 016536-16, 016643-16, 019320-16, 020517-16, 020722-16, 022371-16, 025691-16, 031437-16, 031532-16, 031534-16, 031966-16, 033009-16, 033861-16, 002457-17	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

INA REYNOLDS (524), NATALIE MORONEY (610)

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 5-9, 12-16, 2017.

The following Critical Incident inspections were conducted:
Related to prevention of abuse and neglect:
Log # 016471-16, CI 3047-000034-16
Log # 016536-16, CI 3047-000035-16
Log # 016643-16, CI 3047-000039-16
Log # 022371-16, CI 3047-000064-16
Log # 031437-16, CI 3047-000082-16
Log # 031532-16, CI 3047-000083-16
Log # 031534-16, CI 3047-000081-16
Log # 031966-16, CI 3047-000077-16
Log # 033009-16, CI 3047-000093-16
Log # 033861-16, CI 3047-000096-16
Log # 002457-17, CI 3047-00004-17
Related to prevention of neglect, housekeeping and personal support services:
Log # 020517-16, CI 3047-000058-16
Related to prevention of neglect, palliative care, personal support services, medication administration and equipment:
Log # 020722-16, CI 3047-000060-16
Related to prevention of neglect and safe & secure:
Log # 012217-16, CI 3047-000009-16
Related to personal support services and skin & wound:
Log # 019320-16, CI 3047-000052-16
Related to prevention of neglect, dining and medication administration:
Log # 025691-16, CI 3047-000069-16

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, the Environmental Manager, two physicians, four Registered Nurses, six Registered Practical Nurses, twelve Personal Support Workers, one Housekeeping Aide, one family member and residents.

During the course of the inspection, the inspector(s) also observed residents and the care provided to them, resident and staff interactions, medication administration, reviewed medical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, staff education and training records, reviewed relevant policies and procedures of the home and internal investigation notes.

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

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was provided the opportunity to participate fully in the development and implementation of the plan of care.

Review of a Critical Incident report submitted by the home, indicated that an identified resident was admitted to the home on a specific date with a problem condition to a specific part of their body. Review of the resident's care plan indicated that the resident was to be monitored for signs, symptoms and complications of this specific problem and to apply treatment as per Treatment Administration Record. The resident had been assessed by the physician and had received various treatments for the identified issue since admission. Progress notes indicated that the resident would refuse care by the physician and by staff stating that they did not have this specific identified issue.

On a specific date, the resident was admitted to hospital with an identified diagnosis after a witnessed fall. Once admitted, it was noted that they had an extensive change in a health condition to a specific part of their body. There was no evidence in the clinical record that the Substitute Decision Maker (SDM) was notified of the extent of the condition. On a specific date, the physician noted in a progress note that the SDM had notified them and said that they had no idea of the resident's condition until the resident was brought into the hospital.

In addition, record review showed that the SDM questioned the home and queried why the issue had not been reported to them as they "had no idea of the resident's condition until they were brought to the hospital". The SDM also stated that they were available to assist with care when the resident refused care.

Review of the homes investigation notes and response to the family acknowledged that there were issues with communication from the staff regarding the resident's health condition and stated that "when a significant change occurs it is vital the Power of Attorneys are notified".

The Administrator acknowledged the expectation that the resident's change in health condition should have been communicated to the SDM in order to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. 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.

Review of a Critical Incident report submitted by the Director of Care (DOC) on a specific date, indicated alleged neglect to and identified resident for not providing and ensuring the resident was fed and cared for in a manner which met their needs.

The Critical Incident report said that an identified Personal Support Worker (PSW) had been directed by a Registered Nurse and other staff working that the resident was required to have their meal prior to being sent for treatment on a specific date. The PSW had not provided the resident with a meal and the resident was sent to the hospital not fed.

Review of the care plan for the resident showed that the resident was to be given a meal at a specific time before being sent for an identified treatment.

On a certain date, the PSW received a written disciplinary action form with an unpaid suspension for placing the resident at high risk of harm.

The DOC said that it was the home's expectation that all staff follow the plan of care and all care was provided to the resident as specified in the plan.

The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the 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; and, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

The Resident Assessment Protocol (RAP) report for cognition showed that an identified resident was not able to effectively communicate what they needed and that the residents cognitive performance scale (CPS) indicated impairment of cognition.

Review of a Critical Incident report submitted by the home on an identified date, indicated that a Registered Practical Nurse (RPN) was given a verbal order by a Physician on an identified date, to transfer the resident to hospital to query pain and had not carried out

the action as directed. On an identified date, the resident had been complaining of pain. The Attending Physician had documented in part that the resident had persistent pain and was sent to the hospital and staff were to call if needed.

On a specific date, another Physician documented in PCC in part that the resident had a complaint of pain and noted that the patient had transferred to hospital for investigation of the pain.

On a specific date, a Registered Practical Nurse documented that the resident was comfortable and was not transferred to the hospital.

There was no further documentation in PCC that the residents SDM was notified of the assessment completed by the physician or the order to transfer the resident to the hospital or that the resident had been experiencing pain.

The licensee's Non-Abuse Policy LP-C-25 effective July 2011 and revised on March 2016, stated in part that active neglect can be intentional or deliberate withholding of care or necessities of life to residents.

Review of the homes internal investigation showed that on a specific date, a Registered Nurse (RN) had contacted the physician and provided an update that the resident was never actually transferred to hospital as directed. The Physician was also notified by the RN at this time that the Substitute Decision Maker (SDM) was not notified of the change of condition or that the resident was to be assessed at the hospital for query pain. The Physician was under the understanding that the SDM had been called after the resident's reported pain and that the resident was sent to hospital as ordered.

On a specific date, the RPN was interviewed by the Administrator. The written records of the interview stated in part that they understood what they had done was wrong and they should have sent the resident to the hospital as directed by the physician. The RPN received a written discipline as did an RN for not ensuring the resident was sent to hospital per the physician’s progress notes.

The Administrator notified the residents SDM of the physician’s assessment and that staff were directed to send the resident to the hospital to be assessed for query pain.

The Administrator said that the home's expectation was that when a resident had a change in health status the SDM would be notified and the resident should of been sent

to hospital per the physicians directions.

The licensee had failed to ensure the resident was not neglected by staff and that they were provided with the treatment, care, services or assistance required for their health or well-being and included inaction that resulted in jeopardizing the health and well-being of the resident.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years. [s. 19. (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 residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident

was documented, with a record of immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Care (DOC), the prescriber of the drug and the attending physician or registered nurse in the extended class.

On June 16, 2017, the Inspector and Director of Care (DOC) reviewed reported medication incident reports for April 2017. There was a total of twelve medication incident reports for April. Further review of three incident reports for three residents, showed incomplete documentation on the medication incident reports.

The home's policy titled "Medication Incident Report - 9-1" last reviewed April 2016, stated that "when a medication incident occurs, record it on the Medication Incident Report form and communicate it to proper authorities (e.g. head Nurse/DOC/ADOC/Physician/Pharmacy)".

Documentation of post medication incident assessment or actions taken to assess and maintain residents health were not able to be located for three identified residents.

Documentation of post medication incident notification of the Power of Attorney (POA) was not able to be located for three identified residents.

Documentation of post medication incident notification of the Physician was not able to be located for three identified residents.

On June 16, 2017, the DOC acknowledged there was no POA notification and no physician notification completed post medication incident for the three identified residents.

The licensee had failed to ensure that every medication incident involving a resident was documented, with a record of immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Care (DOC), the prescriber of the drug and the attending physician.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years. [s. 135. (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 every medication incident involving a resident is documented, with a record of immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Care (DOC), the prescriber of the drug and the attending physician or registered nurse in the extended class, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented written or verbal complaint record was kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

A Critical incident (CI) report was submitted by the home for an identified resident. The Administrator reported on the CI that the resident’s Substitute Decision Maker (SDM) had submitted a written complaint on a specific date, to the licensee for alleged neglect to the resident and missing laundry.

Further review of the licensee’s Complaint Form showed that the priority of the concern was both important and non-urgent. The complaint form action and response area, date and time for follow-up to the SDM, the resolution, the supervisor and administrator signatures, and the date of the signatures were not completed on the complaint form.

On July 12, 2017, the inspector asked the Administrator for the home's internal investigation notes related to the written complaint from the SDM and the homes response and action to the complaint. The same documentation was requested from the Director of care during an interview on July 12, 2017.

Review of the licensee's policy Management of Concerns and Complaints, LP-C-15 effective date July 2011, revised date March 2016, outlined in part that once the complaint was completed the corrective action would be implemented, briefing note would be completed and would reflect the date and time the complainant would be contacted, and their responses to the complainant, and that the complaint logs would be kept in the complaint manager binder.

On June 12, 2017, the Administrator and DOC said that they were not able to produce any further records related to the follow-up and responses and actions to the written complaint.

The licensee had failed to ensure that a documented written or verbal complaint record was kept in the home that included the nature of each verbal or written complaint; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years. [s. 101. (2)]

WN #5: 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 a report to the Director under subsection 23 (2) of the Act, included 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.

a) Review of an identified Critical Incident report submitted by the home, showed that the name of the resident allegedly neglected of care by staff was not mentioned in the report.

The Administrator verified that the resident’s name had not appeared in the critical incident report and acknowledged that they should have been included.

b) Review of an identified Critical incident report submitted by the home, by the DOC regarding mandatory reporting on abuse and neglect, showed that the resident involved in the incidents name was not part of the reporting.

On June 16, 2017, the DOC said that they had completed the Critical Incident report and the identified resident's name should have been included on the report.

The licensee had failed to ensure 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.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years. [s. 104. (1) 2.]

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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

Issued on this 13th day of July, 2017

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

Original report signed by the inspector.