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_0013	029088-16, 030369-16, 004006-17, 004777-17	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

INA REYNOLDS (524), JENNA BAYSAROWICH (667), NANCY SINCLAIR (537)

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): June 5-9, 12-16, 2017.

The following complaint inspections were conducted:
Related to prevention of neglect:
Log #029088-16
Log #004006-17
Related to prevention of neglect, personal support services and wound care
Log #009709-17
Related to continence care and personal support services:
Log #030369-16
Related to safe and secure:
Log #004777-17.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Environmental Manager, the Dietary Manager, one Registered Nurse, three Registered Practical Nurses, four Personal Support Workers, one Housekeeping Aide, one Laundry Aide, one Fire Prevention Inspector, two family members and residents.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

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

- **3 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. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Review of a complaint letter submitted to the Ministry of Health and Long-Term Care by a family member stated that an identified resident had to wait two hours for an identified care process which resulted in a negative outcome for the resident. When the resident rang for someone a personal support worker came in, however, did not provide the care to the resident.

Review of a Critical Incident report submitted by the home, identified that the resident reported to nursing staff that they rang the call bell for an identified care process during the shift on a specific date, and a Personal Support Worker refused to provide the identified care process for the resident.

Review of the resident's progress notes on a specific date, documented by registered staff that the resident had requested the identified care process and that the PSW refused to provide the identified care process. Review of the Minimum Data Set (MDS) Quarterly review assessment and the plan of care indicated the resident was dependent on staff for this care process and would be "provided assistance as needed".

Record review showed that the home launched an internal investigation into the incident on a specific date. Review of the disciplinary action form completed by the home stated that the resident had called with the call bell to request the identified care process and the PSW had not provided the care. The resident was cognizant and able to positively identify the PSW during interview. The home concluded that this was not consistent with the resident's care needs and the PSW received a suspension without pay as a result.

Interview with the Director of Care on June 6, 2017, acknowledged that it was the home's expectation that residents were to be provided their identified care process as per their schedule and that staff would always provide care for a resident upon request and provide care in a manner consistent with the resident's needs.

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. 3. (1) 4.]

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 resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

During a telephone call with and identified resident's family member on a specific date, they told the inspector that they had asked a Personal Support Worker (PSW) to use a personal assistive services device (PASD) to transfer the resident for an identified care process. The PSW originally replied to the resident's family member by saying they were not allowed to use the PASD for the identified care process but then honoured the family's request and transferred the resident to provide the care. The resident's family member said the resident appeared to be so relieved once transferred for the care process. Resident's family member also told the inspector that another PSW told them that they did not know the resident could use the identified PASD to transfer the resident.

A review of the clinical record for the resident showed the following:
• A Resident Assessment Instrument Minimum Data Set (RAI-MDS) for a specific date,

which stated the resident required total dependence and physical assistance from staff for the identified care process.
• An identified assessment on a specific date, which stated resident required assistance with the identified care process and that assistive aids were required but did not identify which assistive aids.

On a specific date, the resident told the inspector that staff helped them with the identified care process and when asked if they were able to ring their call bell for assistance they replied yes and pointed to their call bell.

On a specific date, a PSW said staff offered the identified care process to the resident using a specific PASD and that staff provided cueing for resident for the care process. The PSW said the care plan included information about care routines for residents and Point of Care (POC) included information on any care routines for residents who had specialized routines. The PSW stated the resident did not have a specialized care routine that they were aware of.

On a specific date and time, inspector overheard staff providing care to the resident and observed a PASD being brought into the resident's room. When staff came out from providing care, a PSW told the inspector they had just completed the identified care process.

On a specific date, another PSW shared that the resident was to be supervised at all times during the identified care process. The PSW stated they had access to the resident's care plan and Kardex.

No observed information regarding the identified care process utilizing the PASD was found in the resident's bedroom or bathroom.

The Director of Care (DOC) acknowledged that the identified care process was not included in the resident's care plan. When asked if the DOC would expect that the resident's care plan would be updated to reflect their ability to utilize a specific PASD for the identified care process, they acknowledged that it would be expected.

The DOC stated they absolutely agreed that the current information found in the resident's plan of care regarding the identified care process was not clear and stated it was a failure on the home's part.

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. (1) (c)]

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 set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

An observation was completed in a dining room on a specific date and time. A housekeeping cart was left in the dining room unattended, the cart was unlocked and it contained one bottle of Virex 256 cleaner, one bottle of Bathroom Cleaner and Scale remover and one bottle of Oxy Pure Urine cleaner. One bottle of Virex cleaner was observed stored on the outside of the cart. During this time, several residents were observed in the lounge area adjacent to the dining room.

The Housekeeping Aide returned to the housekeeping cart at a specific time and acknowledged that the cart was unlocked and contained bottles of hazardous substances. The Housekeeping Aide indicated that they did not have a key to lock the cart and would report this to the manager.

Upon interview with the Environmental Manager on June 6, 2017, it was stated that housekeeping carts were not kept locked as it saves time for staff. It was the home's expectation that carts containing chemicals were not unattended and staff were to stay approximately three feet within the cart to keep hazardous substances inaccessible to residents at all times.

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. 91.]

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 all hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

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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.