Ontario

Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public
Name of Director:	Karen Simpson
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 X Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	
Licensee:	Sharon Farms & Enterprises Limited 1340 Huron Street London, ON N5V 3R3
LTC Home:	Earls Court Village 1390 Highbury Avenue London, ON N5Y 0B6
Name of Administrator:	Katie Villeneuve-Rector

Background:
On September 22, 2017, as part of the inspection 2017_607523_0021, a Director Referral was made in accordance with s.152, paragraph 4 of *Long-Term Care Homes Act, 2007* (LTCHA). The Director Referral was made after the inspector reissued a second consecutive order to Sharon

Farms & Enterprises Limited in respect of non-compliance found at Earls Court Village under O. Reg. 79/10, s. 31(3). This is the third time that Sharon Farms & Enterprises Limited has been found to be in non-compliance with the O. Reg. 79/10, s. 31(3) since 2014. As part of the Director's Referral, the Director has considered the scope and severity of the non-compliances identified in inspection 2017_607523_0021, along with the licensee's history of compliance, and has determined that it is necessary to issue this Order.

Order:	**#001 – Sharon Farms & Enterprises Limited** **Amended December 21, 2017 to amend the Compliance Due Date**

To Sharon Farms & Enterprises Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to the following Legislative and Regulatory requirements:

1) O. Reg. 79/10, s. 31(3) The licensee shall ensure the home's staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
O. Reg. 79/10, s. 31 (3).

2) O. Reg. 79/10, s. 8(1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the license is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with.

3) LTCHA, 2007, S.O. 2007, c. 8, s. 20(1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that

the policy is complied with, and

4) LTCHA, 2007, S.O. 2007, c. 8, s. 24. (1) A person who has reasonable ground 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 a 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.**

Order:

1) To bring in a consultant from an external company with extensive experience in managing or operating LTC homes to conduct a review and make recommendations for improvement regarding the following:

   a. The nursing program within the home to ensure it is organized to meet the assessed needs of the residents;

   b. The program of personal support services for the home to ensure it is organized to meet the assessed needs of the residents;

   c. The staffing plan within the home to ensure it meets the assessed needs of residents and is evaluated and updated as necessary.

2) Upon completion of the review the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and findings must be finalized no later than November 30th, 2017.

   Within two weeks of receiving the report from the review, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the timelines for implementation. That plan will be reviewed by the Director and may be changed based on the Director's review of the report from the review and the plan submitted by the licensee. Upon approval of the plan by the Director, the licensee will implement the actions identified.

3) To bring in a nursing consultant from an external company with extensive experience in managing or operating LTC Homes to review the home's nursing practices and provide on-site and in-person training to all registered staff on the College of Nurses' Standards of Practice and Guidelines relating to the Safe Administration of Drugs and Documentation. This training will also be provided to the Administrator and the President/CEO of 'Sharon Farms &

Enterprises Limited' to ensure that they understand the regulated practices required of their registered nursing staff in accordance with the College of Nurses' Standards of Practice.

4) To prepare and implement a plan to provide in-person training for staff on the prevention of abuse and neglect, including what constitutes abuse and neglect, mandatory reporting obligations and the licensee's policy to promote zero tolerance of abuse and neglect in accordance with the requirements of the LTCHA and O. Reg. 79/10.

5) Review, update and provide a copy of the policy to promote zero tolerance of abuse to the Director under the Act. The policy must ensure it is in compliance with the LTCHA and reflect a process that requires the person who suspects or witnesses abuse to immediately report the suspicion or observations of abuse to the Director.

All of the plans are to be submitted to Karen Simpson, Director, by fax to 613-569-9670 or courier to 347 Preston Street, Suite 420, Ottawa, Ontario, K1S 3J4 by October 27, 2017.

Grounds:

This Order is necessary given the scope and severity of the non-compliances identified in inspection #2017_607523_0021 outlined below. This Order is being issued to ensure the licensee achieves compliance with the serious and on-going non-compliance identified below by taking the actions identified by the Director in this Order, in addition to the actions identified by inspectors in the compliance order issued following Inspection #2017_607523_0021.

As Director, I have relied on the evidence gathered in Inspection #2017_607523_0021. I have reviewed the inspection reports, the Orders issued and the evidence collected by the inspectors. I have also reviewed the inspectors' analysis of the scope, severity and the compliance history associated with the non-compliance identified and have determined that this Director's Order is warranted given that non-compliance with O. Reg. 79/10, s. 31(3) was found at Earls Court Village in a second consecutive inspection, the evidence gathered, the inability of the licensee to achieve compliance and the other non-compliance found in the inspection.

This Director's Order is being issued considering the compliance history of the licensee with respect to the legislative requirements identified below and the recent management and staffing instability which is contributing to the non-compliance within the home.

The recent management instability included:

- Turnover of the management team:
    - The Director of Care (DOC) was on leave for three weeks in August 2017. During this period, coverage was provided by a Registered Nurse (RN) whose qualifications for this position did not meet the legislative requirements as Director of Nursing and Personal Care.

- The Director of Dietary Services resigned and a new Director of Dietary Services was hired just prior to the inspection.
- The Director of Recreation submitted their letter of resignation one week prior to inspection.
- Two (2) different Assistant Directors of Care (ADOCs) were hired and resigned since April 2017. No replacements had been hired at the time of the inspection.
- The Business Manager resigned in April 2017. A new manager was hired and was receiving orientation at the time of the inspection. Interviews with staff indicated that this change caused a significant increase in workload leading to management staff resignations and leaves.
- Senior management identified that they had wanted to increase PSW staffing on the weekends given the higher levels of absenteeism but the request was denied by the licensee.

The staffing shortages resulted in residents not receiving the care they required. Detailed evidence is provided in inspection report #2017_607523_0021 and includes:

- Bathing twice a week was not completed for some residents.
- Positioning per plan of care was not completed.
- Releasing and reapplying of restraints was not completed.
- Toileting per plan of care was not completed.
- RN was covering two resident care areas, delaying treatments and causing medications to be administered over two hours late.

The areas of non-compliance issued in inspection #2017_6017523_0021 and that are relevant to this Order are detailed below and include non-compliance with O. Reg. 79/10, s. 31(3), O. Reg. 79/10, s. 8(1), LTCHA, 2007, S.O. 2007, c. 8, s. 20(1) and LTCHA, 2007, S.O. 2007, c. 8, s. 24(1). Direction is being provided in this Order to ensure the licensee takes action, in addition to the actions ordered by the Inspectors, to address the following areas of non-compliance:

- In response to non-compliance related to **O. Reg. 79/10, s. 31 (3):**
  - The licensee is required to initiate a review of the nursing, personal support services program in the home to ensure they are structured to meet the needs of the residents. In addition, the licensee is ordered to ensure the staffing plan is reviewed to ensure it meets the needs of residents and their assessed care needs. Upon review, the licensee will be required to act on any recommendations from that review.
- This action by the licensee is being required because of the staffing shortages detailed in the inspection report which impacted multiple areas of resident care, as noted above. They were not isolated to a specific resident care concern or a specific unit within the home. In June 2017, there were shortages of 15 personal support worker shifts and 2 registered practical nurse shifts. In July 2017, there were shortages for 24 personal

support worker shifts and from August 1to 21, 2017, there were shortages of 41 personal support worker shifts and 12 registered practical nurse shifts. As evidenced through the inspection, the staffing shortages were getting significantly worse over the summer. The Administrator confirmed to the inspector that they had one RN line, four RPN and five PSW lines vacant. Interviews with residents and staff throughout the home demonstrated that the home was regularly short of staff. Despite the administration team in the home analyzing and tracking where the shortages occurred and identifying solutions, the licensee did not put in place strategies or actions to address the staffing shortage.

- The Ministry received multiple complaints related to staffing shortages impacting resident care and upon inspection, non-compliance was identified. The non-compliance and evidence to support it is detailed in the inspection report. In one case, one of the residents said that the home area was always short of staff and the resident had to wait for everything. A review of the call bell log shows that this same resident on multiple occasions waited for 13 minutes, 15 minutes, 21 minutes and on another occasion 36 minutes to receive assistance.

- Given the issues above and outlined in more detail in the inspection report, the licensee has not been able to put in place strategies to effectively address the requirements of the LTCHA and ensure there is a staffing mix that is consistent with the residents' assessed care and safety needs. It is for these reasons that I am ordering the licensee to bring in an external consultant with expertise in long-term care to analyse the current staffing plan and prepare recommendations, as the licensee has not been able to put in place strategies to effectively address the issues themselves.

- In response to non-compliance related to **O. Reg. 79/10, s. 8.(1):**
  - In-person training is required to be provided by an external nursing consultant to registered staff and including the Administrator and President/CEO on the College of Nurses Standards of Practice and Guidelines relating to Safe Administration of Drugs and Documentation.
  - This is required because evidence from inspection #2017_607523_0021 demonstrated that registered staff did not follow the College of Nurses Standards of Practice and Guidelines related to Safe Administration of Drugs and Documentation and because the licensee did not fully understand or appreciate these requirements.

- In response to non-compliance related to **LTCHA, 2007, S.O. 2007, c. 8, s. 20(1):**
  - A plan is required to be developed and implemented to provide in-person training for staff on the home's policy on prevention of abuse and neglect and the content of that policy, and ensuring that the policy meets all of the mandated requirements of the legislation prior to training being initiated. The policy must also reflect a process that requires the person who suspects or witnesses abuse to report the suspicion or observations of abuse to the Director.
  - This is required because evidence from inspection #2017_607523_0021

demonstrated that staff had not reported suspected, witnessed or alleged abuse to the Director or to senior staff within the home and to ensure the policy adheres to the legislative requirements outlined in s. 24(1) of the LTCHA requiring the person who suspects or witnesses the abuse and/or neglect to report the suspicion or observations of abuse immediately to the Director. The evidence gathered in the inspection does not identify that the current process includes that requirement but instead requires the person who witnesses or suspects the abuse or neglect to report it to the Administrator or a senior supervisor on shift.

- In response to non-compliance related to **LTCHA, 2007, S.O. 2007, c. 8, s. 24. (1):**
  - In-person training is to be provided so that staff understand their obligations with respect of ensuring residents are protected from abuse and neglect, including reporting abuse and neglect in accordance with the legislated requirements;
  - As noted in the previous non-compliance this is required because staff did not take the appropriate action to report suspected abuse in accordance with their reporting obligations either under the LTCHA or in accordance with the home's policy.

Specific evidence of the non-compliance identified and that is relied on by the Director is contained within the inspection reports noted below.

O. Reg 79/10, S. 31(3):

- **September 18, 2017**: A complaint inspection was conducted on August 17, 18, 21 and 22, 2017. The inspection report for inspection #2017_607523_0021 and Director Referral issued for CO #005 was served on the licensee September 18, 2017, with a compliance due date of October 31, 2017. The Director Referral is in relation to O. Reg 79/10, s. 31 (3) The licensee failed to ensure that the staffing plan provided a staffing mix that was consistent with residents' assessed care and safety needs.

- **March 8, 2017:** Written Notification, Compliance Order #001 and a Director Referral #001, under Resident Quality Inspection # 2016_229213_0005. Compliance Order was complied with on April 14, 2017.

- **February 27, 2014**: Written Notification and Voluntary Plan of Correction under Complaint Inspection # 2015_259520_0004.

- **December 24, 2014:** Written Notification, and a Voluntary Plan of Correction under Complaint Inspection # 2014_303563_0061.

LTCHA, 2007, s. 20. (1):

- **September 18, 2017**: A complaint inspection was conducted on August 17, 18, 21 and 22, 2017. The inspection report for inspection #2017_607523_0021 and Compliance Order #001 was served on the licensee on September 18, 2017, with a compliance due date of

October 31, 2017. The Order was in relation to the licensee failing to ensure that the written policy to promote zero tolerance of abuse and neglect is complied with, specifically but not limited to, when staff suspect or are informed of any witnessed or alleged abuse.

- **January 4, 2016**- A Critical Incident Inspection was conducted # 2015_303563_0055 and non-compliance was issued for s. 20(1).

LTCHA, 2007, S.O.2007, c.8, s. 24. (1):

- **September 18, 2017:** A Complaint Inspection was conducted on August 17, 18, 21 and 22, 2017. The inspection report for inspection #2017_607523_0021 and Compliance Order # 002 was served on the licensee on September 18, 2017, with a compliance due date of October 31, 2017. The Order was in relation to the licensee failing to ensure that when a person who had reasonable grounds to suspect that any abuse of a resident by anyone has occurred or may occur, that they have immediately reported the suspicion and the information upon which it was based to the Director.

- **March 8, 2016** – A Resident Quality Inspection (RQI) # 2015_229213_0005 was conducted and the Compliance Order (CO) originally issued on January 4, 2016 was re-issued and then subsequently complied on April 26, 2016.

- **January 4, 2016** – A Complaint Inspection # 2015_30356_0054 was conducted and a Compliance Order #001 was issued and that Order was then re-issued on inspection #2016_229213_0005.

- **June 26, 2015** – A Complaint Inspection #2015_229213_0022 was conducted. Non-compliance was identified with a Voluntary Plan of Correction.

- **May 20, 2015** – A RQI #2015_416515_0013 was conducted. Non-compliance was identified with a Voluntary Plan of Correction (VPC).

- **February 13, 2015**- A Critical Incident Inspection #2015_260521_0007 was conducted. Non-compliance was identified with a Written Notification (WN).

O. Reg.79/10, s, r. 8. (1) (b:

- September 18, 2017 – A Complaint Inspection #2017_607523_0021 was conducted. A CO #004 was issued with a due date of October 31, 2017. The Order required the licensee to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically but not limited to, Medication/Treatment Administration Records.

- March 8, 2016 – A RQI # 2015_229213_0005 was conducted where non-compliance with

a VPC was identified.

Previous Director Referrals & Cease of Admissions - 2016

- **March 8, 2016:** A Resident Quality Inspection was conducted on January 20 – February 5, 2016. The inspection report for inspection 2016_229213_0005 and Director Referral(s) issued for CO# 006 and CO# 010 was served on the licensee March 8, 2016. The Director Referral(s) were in relation to LTCHA, 2007 s. 84 – failing to implement a Quality Improvement Program; and O. Reg. 79/10, s. 101- dealing with complaints. In addition to the 2 DRs, the 37 WN, 22 VPC and 16 COs were issued as a result of the RQI.

Non-compliances included the following WN & COs and 2 Directors Referrals (DR)

- **LTCHA 2007, c 8, s. 76 (1)** – due March 31/16 → Follow-up (FU), Complied May 11/16
- **LTCHA 2007, c 8, s. 24 (1)** – due March 11/16 → FU, Complied May 11/16
- **LTCHA 2007, c 8, s. 31 (3)** – due April 4/16 → FU, Complied May 11/16
- **LTCHA 2007, c 8, s. 6 (1) (c)-** due April 4/16 → FU re-issued → FU, Complied June 23/16
- **LTCHA 2007, c 8, s. 6 (2)** – due April 4/16 → FU re-issued x2 → FU, Complied July 20/16
- **LTCHA 2007, c 8, s. 6 (7)** – due April 4/16 → FU re-issued x2 → FU, Complied July 20/16
- **LTCHA 2007, c 8, s. 6 (8)** – due April 4/16 → FU, Complied May 11/16
- **LTCHA 2007, c 8, s. 6 (10)** – due April 4/16 → FU, Complied May 11/16
- **LTCHA 2007, c 8, s. 3(1)(4)** – due April 4/16 → FU re-issued → FU, Complied June 23/16
- **LTCHA 2007, c 8, s. 8 (3)** – due June 6/16 → FU, Complied June 23/16
- **LTCHA 2007, c 8, s. 23** – due June 6/16 → FU, Complied June 23/16
- **LTCHA 2007, c 8, s. 86 (1)** – due July 4/16 → FU, Complied July 20/16
- **LTCHA 2007, c 8, s. 84 – (DR)** due Sept 6/16 (DR) → FU, Complied July 20/16
- **LTCHA 2007, c 8, s. 19 (1)**– Immediatiate → FU, Complied June 23/16
- **O. Reg. 79/10 s. 101- (DR)** due July 4/16 → FU, re-issued → FU, Complied July 20/16
- **O. Reg. 79/10 s. 15 (1) -** due June 6/16 → FU, re-issued → FU, Complied July 20/16
- **O. Reg. 79/10 s. 229 (10) -** due June 6/16 → FU, Complied June 23/16
- **O. Reg. 79/10 s. 48 (1)** – due July 4/16 → FU, Complied July 20/16

Additional non-compliances WN & VPC:

- **WN / VPC** – O. Reg. 79/10, s. 33 (1) – Bathing
- **WN / VPC -** O. Reg. 79/10, s. 8 (1) – Policy re: personal care supplies
- **WN / VPC -** O. Reg. 79/10, s. 26 (3) – Plan of Care interdisciplinary assessment
- **WN/ VPC -** O. Reg. 79/10, s. 50 (2) – Skin and Wound
- **WN/ VPC -** O. Reg. 79/10, s. 51 (1) – Continence care products
- **WN / VPC -** O. Reg. 79/10, s. 52 (2) – Pain management
- **WN / VPC** O. Reg. 79/10, s. 57(2) – Response to Residents' Council concerns
- **WN / VPC** O. Reg. 79/10, s. 60 (2) – Response to Family Council concerns
- **WN / VPC** O. Reg. 79/10, s. 68 (2) – Nutrition & Hydration
- **WN / VPC** O. Reg. 79/10, s. 73 (1) – Snack Service

- **WN / VPC** O. Reg. 79/10, s. 76 (2) – Mandatory Training
- **WN / VPC** O. Reg. 79/10, s. 85 (4) – Satisfaction Survey
- **WN / VPC** O. Reg. 79/10, s. 90 (1) – Maintenance
- **WN / VPC** O. Reg. 79/10, s. 117 – Medical Directives and orders
- **WN / VPC** O. Reg. 79/10, s. 123 – Emergency Drug Supply
- **WN / VPC** O. Reg. 79/10, s. 129 & 130– Safe Storage of Drugs
- **WN / VPC** O. Reg. 79/10, s. 131- Administration of Drugs
- **WN / VPC** O. Reg. 79/10, s. 134 – Residents' Drug Regime
- **WN / VPC** O. Reg. 79/10, s. 135 – Medication incidents
- **WN / VPC** O. Reg. 79/10, s. 27 – Care Conferences
- **WN / VPC** O. Reg. 79/10, s. 79 (3) –Posting of information
- **WN / VPC** O. Reg. 79/10, s. 89 –Laundry

- **March 14, 2016: Cease of Admissions** effective – as per leadership instability and multiple areas of non-compliance and compliance orders, as outlined below.

- **July 27, 2016: Cease of Admissions Lifted**. Noting Administrator and DOC positions secured, and compliance status improved / all CO's complied as per outlined below.

This Order must be complied with by:	February 15, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Amended and re-issued on this 21st day of December, 2017.	
Signature of Director:	Karen Simpson
Name of Director:	Karen Simpson

Version date: 2017/02/15