Ontario

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

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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:	Stacey Colameco
Order Type:	□ Amend or Impose Conditions on Licencee Order, section 104 □ Renovation of Municipal Home Order, section 135 □ Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 X Mandatory Management Order, section 156 □ Revocation of Licencee Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	
Licensee:	Sharon Farms & Enterprises Limited
LTC Home:	Earls Court Village
Name of Administrator:	Katie Villeneuve-Rector

Background:

Sharon Farms & Enterprises Limited is licensed to operate a long-term care home known as Earls Court Village located at 1390 Highbury Avenue, London, Ontario.

Earls Court Village ("the home") is a long-term care home in London, Ontario within the South West Local Health Integration Network (LHIN). Sharon Farms & Enterprises Limited ("the licensee") is licensed for 128 long-stay beds in the home.

On March 14, 2016, the Director under the *Long-Term Care Homes Act, 2007* (LTCHA) directed the local placement co-ordinator to cease admissions to the home, pursuant to s. 50 (1) of the LTCHA, on the belief that there was a risk of harm to the health or well-being of

residents in the home or persons who might be admitted as residents. This was based on findings from a Resident Quality Inspection (RQI) conducted from January 20 to February 5, 2016, which resulted in 16 compliance orders issued to the licensee and two Director Referrals. This cease of admissions initiated on March 14, 2016 and was lifted on July 27, 2016.

On October 2, 2017, the Director under the LTCHA directed the local placement coordinator to cease admissions to the home. This was based on findings from a complaint inspection (2017_607523_0021) conducted on August 17, 18, 21 and 22, 2017, which resulted in a Director's Referral and five compliance orders issued to the licensee, three of which had been re-issued multiple times previously during a follow-up inspection. This cease of admissions initiated on October 3, 2017 and continues to remain in effect.

Subsection 156(1) of the LTCHA states that the Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home. Subsection 156(2) of the LTCHA states that an order may be made under this section if: (a) the licensee has not complied with a requirement under the LTCHA and (b) there are reasonable grounds to believe that the licensee cannot or will not properly manage the long-term care home or cannot do so without assistance.

In addition, the Director has considered the factors under s. 299(1) of the Regulation in determining to issue this Order, which requires the Director to take into account the licensee's severity of non-compliance, scope of non-compliance, and history of compliance.

As set out below, the licensee has not complied with several requirements under the LTCHA and the Director has reasonable grounds to believe that the licensee cannot or will not properly manage the long-term care home.

Order:	

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: *Long Term Care Homes Act,* 2007 S.O. 2007, c.8 s. 156. (1). The Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home.

Order: Sharon Farms & Enterprises Limited ("the licensee") is ordered:

(a) to retain one or more persons, at your expense, described in paragraph (c) or (d) of this Order, to manage Earls Court Village located at 1390 Highbury Avenue, London, Ontario ("the long-term care home");

(b) to submit to the Director within **14 calendar days** of being served with this Order a proposed person(s) described in paragraph (a) to this Order;

(c) the person(s) described in paragraph (a) to this Order must be acceptable to the Director and approved by the Director in writing;

(d) if the licensee does not submit a proposed person(s) described in paragraph (a) to this Order to the Director within the time period specified in paragraph (b) to this Order, the Director will select the person(s) that the licensee must retain to manage the long-term care home;

(e) the person(s) described in paragraph (a) to this Order acceptable to the Director will have specific qualifications, including:

(i) the experience, skills and expertise required to operate and manage a long-term care (LTC) home in Ontario and to maintain compliance with the LTCHA and Regulation;

(ii) have a good Compliance Record, which for the purpose of this Order means the LTC home for which the person described in paragraph (a) to this Order is a licensee or manager, or to which the person described in paragraph (a) to this Order provides consulting services has a compliance record under the LTCHA that is considered to be Substantially Compliant including:

1. critical incidents that occur are reported as required;
2. complaints are managed effectively in the LTC home;
3. the LTC home develops policies/procedures using evidenced based practice and quality strategies
4. the LTC home responds to issues identified during inspections; and
5. non-compliance in areas of actual harm or high risk of harm to residents and any other persons identified during inspections are rectified within the time

frame required by the inspector.

(iii) demonstrate that they have not, under the laws of any province, territory, state or country, in the three years prior to this Order;

1. been declared bankrupt or made a voluntary assignment in bankruptcy;
2. made a proposal under any legislation relating to bankruptcy or insolvency; or
3. have been subject to or instituted any proceedings, arrangement, or compromise with creditors including having had a receiver and/or manager appointed to hold his, her, or its assets.

(f) to submit to the Director a written contract pursuant to section 110 of the LTCHA **within 14 calendar days** of receiving approval of the Director pursuant to paragraph (c) of this Order or the selection of a person(s) pursuant to paragraph (d) of this Order;

(g) to execute the written contract **within 24 hours** of receiving approval of the written contract from the Director pursuant to section 110 of the *Long-Term Care Homes Act, 2007* and to deliver a copy of that contract once executed to the Director;

(h) to submit to the Director a management plan, prepared in collaboration with the person described in paragraph (a) to this Order, to manage the long-term care home and that specifically addresses strategies to achieve compliance with those areas identified as being in non-compliance **within 30 calendar days** of receiving approval of the Director pursuant to paragraph (c) of this Order or the selection of a person pursuant to paragraph (d) of this Order;

(i) the person approved by the Director pursuant to paragraph (c) to this Order or selected by the Director pursuant (d) of this Order, shall begin managing the home in accordance with the written contract described in paragraph (g) to this Order **within 24 hours** of the execution of that written contract;

(j) the management of the home by the person described in paragraph (a) to this Order is effective until advised otherwise by the Director; and

(k) any and all costs associated with complying with this Order are to be paid for by the licensee, including for certainty, but not limited to, all costs associated with retaining the person described in paragraph (a) to this Order.

Grounds:

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007*

The licensee has not complied with the following requirements under the *Long-Term Care Homes Act, 2007.* This Order relies on the inspection file, findings and any Orders issued as part of the inspections identified below.

On August 17 to 22, 2017, Inspectors conducted a Complaint Inspection (2017_607523_0021) and issued 7 written notifications, 2 voluntary plans of correction, 5 compliance orders and 1 Director's referral. This included the licensee's non-compliance with the following:

- LTCHA, s. 20. (1), The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was not complied with. The inspector found that staff in the home who were aware of alleged resident to resident abuse, did not immediately report this to the management in the home as per the home's policy.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with, specific but not limited to, when staff suspect or are informed of any witnessed or alleged abuse.

- LTCHA, s. 24. (1), The licensee failed 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, to immediately report the suspicion and the information upon which it was based to the Director. The inspector found that there was an incident of alleged resident to resident abuse which was not immediately reported to the Director by the licensee.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, that the suspicion and the information upon which it is based be immediately reported to the Director.

- LTCHA, s. 75, The licensee failed to ensure that screening measures including criminal reference checks were conducted in accordance with O. Reg. 79/10 (Regulation) under the LTCHA before hiring staff and accepting volunteers.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that screening measures, including criminal reference checks, were conducted in accordance with the Regulation before hiring staff and accepting volunteers.

- Regulation, s. 8. (1) (b), The licensee failed to ensure that the home's medication policy was complied with. The inspector found that the home's medication policy was not complied with as a registered nursing staff member had documented the administration of medications under another staff member's name.

  A compliance order was issued pursuant to section 153(1)(a) ordering 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.

- Regulation, 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. Specifically, the inspectors found staffing shortages on various shifts and that residents were not receiving the care they required including bathing twice a week, positioning as per the plan of care and toileting as per the plan of care.

  A Director's referral and compliance order was issued pursuant to section 153(1)(a), ordering the licensee to ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.

- Regulation, s. 129, The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked. This was issued as a written notification and voluntary plan of correction.

- Regulation, s. 213. (4), The licensee failed to ensure that the Director of Nursing and Personal Care (DONPC) had a least three years' experience working as a registered nurse in a management or supervisory capacity in a health care setting. This was issued as a written notification and voluntary plan of correction.

On September 22, 2017 as part of the Director's referral issued during Complaint Inspection (2017_607523_0021) mentioned above, non-compliance was found with Regulation, s. 31. (3), The licensee failed to ensure that the staffing plan provide for a staffing mix that is consistent with residents' assessed care and safety needs.

The Director found that based on the evidence collected by the inspectors, the compliance history of the licensee and the management and staffing instability which was contributing to the non-compliance in the home, a Director's Order was warranted. A Director's Order was issued pursuant to sections 153(1)(a)(b), ordering the licensee:

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 specific programs within the home.

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. 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 submitted by the licensee will be reviewed by the Director and may be changed based on the Director's review of the report. 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 to review the home's nursing practices and provide on-site and in-person training to all registered staff as well as 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 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.

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. The areas of non-compliance issued in inspection #2017_6017523_0021 relevant to this Order includes 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 was provided in this Order to ensure the licensee also takes action to address these areas of non-compliance.

On November 14 to 23, 2017, inspectors conducted a critical incident system inspection (2017_607523_0033) and issued 8 written notifications, 3 voluntary plans of correction, and 3 compliance orders, including identifying the following non-compliance:

- Regulation, s. 30, The licensee failed to ensure, in respect to each of the interdisciplinary programs required under section 48 of this Regulation that there was (1) a written description of the program that includes its goals and objectives and relevant policies, procedures and (2) provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources were required.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that at least annually, in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, that a written record is kept relating to each evaluation that includes the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented relating to the home's Skin and Wound Program, Falls Management Program, Pain Management

Program and Continence Care and Bowel Management Programs.

- Regulation, s. 53. (3), The licensee failed to ensure that the responsive behaviour program was evaluated at least annually.

  A compliance order was issued pursuant to section 153(1) (a) ordering the licensee to ensure that the home developed and implemented the requirements referred to in subsection 53. (1) in accordance with evidence-based practices and if there are none, in accordance with prevailing practices; to ensure that at least annually these requirements were evaluated; and a written record is kept relating to each evaluation including the date of the evaluation; the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

- Regulation, s. 54, The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions.

- Regulation, s. 17, The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that at all times, was on and could be easily seen, accessed and used by residents, staff and visitors. A written notification and voluntary plan of correction were issued.

- Regulation, s. 107, The licensee failed to ensure that the Director was informed of an incident of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report of the incident that caused an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the health condition of a resident. This was issued as a written notification and voluntary plan of correction.

- Regulation, s. 8. (1) (b), The licensee failed to ensure that where the LTCHA or the Regulation requires the licensee of a home to have, institute or otherwise put in place any plan, policy, protocol, procedure strategy or system, the licensee is required to ensure they were complied with. The licensee failed to comply with the home's Medication Management System relating to medication incidents; the homes policy titled Falls

Intervention Risk Management under the homes required Falls Prevention Program. This was issued as a written notification.

- LTCHA, s. 20, The licensee failed to ensure that the homes written policy to promote zero tolerance of abuse and neglect of residents was complied with. This was issued as a written notification.
- LTCHA, s. 23, The licensee failed to report to the Director the results of every investigation undertaken related to alleged neglect and abuse of a resident, and every action taken in response to this incident. This was issued as a written notification.

On November 14 to 23, 2017, Inspectors conducted a complaint inspection (2017_607523_0032) and issued 2 written notifications, 2 voluntary plans of correction, and 1 compliance order, which included the following non-compliance:

- LTCHA, s. 6. (10), The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan had not been effective relating to a post fall assessment of a resident.

  A compliance order was issued pursuant to section 153(1) (a) ordering the licensee to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change and the care set out in the plan has not been effective.
- LTCHA, s. 6. (2), The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident as related to the hygiene needs of the resident. This was issued as a written notification and voluntary plan of correction.
- Regulation, s. 50. (2), The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. This was issued as a written notification and voluntary plan of correction.

On March 12 to April 18, 2018, inspectors conducted the Resident Quality Inspection (RQI) (2018_722630_0007) and issued 31 written notifications, 9 voluntary plans of correction, 20 compliance orders, and 2 Director referrals. This included non-compliance with the following:

- LTCHA, s. 6. (10) (b), The licensee failed to comply with compliance order #001 from inspection 2017_607523_0032, relating to the falls prevention program. Inspectors found that the licensee did not ensure re-assessment of two residents' and the plans of care had not been reviewed and revised at any time when the residents' condition and care needs changed, and found that staff did not respond to care needs expressed by a resident. This

compliance order remains outstanding.

Additionally, the inspectors identified that the licensee failed to ensure that the plan of care for residents met the legislative requirements of section 6 of the LTCHA, including:

s. 6. (1) (a) (c), The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident; and clear directions to staff and others who provide direct care to the resident. This related to: a) a resident with a seatbelt and b) clear direction for staff re: bowel protocol.

s. 6. (2), The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. This related to: residents recreational needs/activities, residents fall prevention needs, and residents continence care needs.

s. 6. (7), The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. This related to: safe positioning of residents, falls prevention, and safe use of seatbelts.

s. 6. (9) (1) (2), The licensee failed to ensure that the provision of the care, and outcomes of care set out in the plan of care was documented. This related to: a) falls prevention measure for a resident and b) resident's activities of daily living (ADLs).

A compliance order was issued pursuant to section 153(1) (a) ordering the licensee to ensure that in regards to the plan of care for identified residents and any other resident that: the plan of care is reviewed and revised when care needs change; that there is a written plan of care for each resident which sets out the planned care; that the care set out in the plan of care is based on an assessment of the resident; that the plan of care provides clear direction for staff; that the care set out in the plan is provided to the resident; and the provision of care is documented.

- LTCHA s.19 (1), The licensee failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff. The inspectors found that staff in the home failed to provide an identified resident with the care and assistance required to maintain their safety and well-being related to falls prevention and post fall assessments.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to a) ensure that when a table tray device is broken and/or not available to be used for an identified resident, as specified in the plan of care, that actions are taken immediately to ensure the safety of that resident, b) develop and implement measures in the home to ensure that an identified resident and every other resident is provided with the required assessments, treatments, care or assistance required for their safety. The home must maintain a documented record of the measures that have been developed and

implemented; the persons involved in the implementation, and monitoring of interventions as they relate to the safety needs of residents living in the home, and dates when changes were implemented.

- LTCHA, s. 20. (1), The licensee failed to comply with compliance order #001 from inspection 2017_607523_0021 served on September 22, 2017 with a compliance date of October 31, 2017 relating to the home's policy to promote zero tolerance of abuse and neglect of residents. The inspectors found that the management in the home did not comply with the home's written policy related the completion and documentation of internal investigations.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure:

  a) that the policy to promote zero tolerance of abuse and neglect of residents is complied with, specific to but not limited to 1) the immediate reporting of the allegation of abuse or neglect to the management in the home and 2) the documentation of the home's investigation

  b) complete an analysis promptly after each incident of alleged abuse or neglect to ensure that the policy of zero tolerance of abuse and neglect of resident has been complied with and that changes and improvements are promptly implemented.

  The analysis and improvements implemented must be documented.

- LTCHA, s. 24. (1), The licensee failed to comply with compliance order #002 from inspection 2017_607523_0021 served on September 22, 2017 with a compliance date of October 31, 2017. The inspectors found that allegations of neglect were not immediately reported to the Director by the management in the home.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that when any person has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director: 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.

- LTCHA, s. 101. (3), The licensee failed to comply with a condition of every licensee that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Act 2007. C. 8, s. 195 (12). The licensee failed to comply with the Director Order #001 in relation to inspection 2017_607523_0021 (A1) served on December 21, 2017, with a compliance date of February 15, 2018.

  The Inspectors found that the licensee did not comply with Steps #2, #3 and #4 of the

Director's Order as it related to the Compliance Action Plan submitted to the Director on December 14, 2017 and approved by Director on December 18, 2017. Regarding Step #2 of the Director Order, inspectors identified that several areas of the Compliance Action Plan had not been implemented; Step #3 of the Director Order inspectors identified that the external company did not review the nursing practices before providing the required staff training; Step #4 of the Director Order, inspectors identified that agency staff had not been provided the required education with in person training on the home's policy to promote zero tolerance of abuse and neglect. This was issued as a written notification and Director's Referral.

- Regulation, s. 8. (1) (b), The licensee failed to comply with compliance order #004 from inspection 2017_607523_0021 served on September 22, 2017, with a compliance date of October 31, 2017. The inspectors found that the licensee failed to ensure that multiple required policies that had been instituted in the home were complied, including: policies relating to the home's Medication Management System; the outbreak management policy within the home's Infection Prevention and Control Program; policy relating to post-falls assessments residents as part of the home's Falls Prevention Program; policy related to the monitoring of bowel management as part of the Continence Care and Bowel Management Program; policy related to the residents' Trust Accounts.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to:

  a) ensure that the home's Infection Prevention and Control program policies and strategies related to outbreak management are complied with,

  b) ensure that the leadership team, all Registered Nurses (RNs) and all Registered Practical Nurses (RPNs) working in the home are re-educated on the Infection Prevention and Control program policies and strategies related to outbreak. The home must keep a documented record of the education provided,

  c) ensure the home's Falls Prevention and Management program policies and procedures are complied with,

  d) ensure that RNs, RPNs, PSWs leadership team members working in the home are re-educated on all the home's Falls Prevention policies and procedures. The home must keep a documented record of the education provided,

  e) ensure that the home's policy and procedures for the management of resident trust accounts and the petty cash trust money are complied with, and

  f) ensure that the home's policy and procedures related to the Medication Management System are complied with,

  g) ensure the home's Continence Care and Bowel Management program policies related to

monitoring resident bowel movements are complied with.

- Regulation s. 31. (3), The licensee has failed to comply with compliance order #005 and Director Referral issued from inspection 2017_607523_0021 (A1) served on February 6, 2018 (*original date served September 22, 2017*) with amended compliance date of February 15, 2018. And, the licensee failed to comply with Director Order #001 served on December 21, 2017, with a compliance date of February 15, 2018. The inspectors found staffing shortages on various shifts over a lengthy time period; resident care needs not provided and delayed response times to residents care needs relating to pain management, bladder and bowel continence care and toileting needs, skin and wound needs, repositioning of residents re: PASDs, residents nutritional needs, including feeding and assistance with eating, food quality i.e. temperature needs. This compliance order remains outstanding.

  A compliance order and Director Referral was served on the licensee pursuant to section 153(1)(a) ordering the licensee to:

  a) develop, document and implement a process in the home to identify the assessed care and safety needs of the residents in each home area,

  b) based on the identification of the assessed care and safety needs of the residents in the each home area, review and update the written staffing plan in the home to ensure it provides for a staffing mix that is consistent with the residents' needs.

- Regulation s. 49. (2), The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

  A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to:

  a) ensure when two identified residents and any other resident has fallen that the resident is assessed by a registered nursing staff member,

  b) ensure that the home's Falls Prevention and Management program policies and procedures are complied with regarding the completion and documentation of post fall assessments for residents,

  c) ensure that all Registered Nurses, Registered Practical Nurses, Personal Support Workers and leadership team members in the home are re-educated on all of the home's Falls Prevention policies and procedures including the procedures in the hone for falls prevention and post fall assessments. The home must keep documented record of the education provided.

- Regulation s. 53. (3), The licensee failed to comply with compliance order #002 from inspection 2017_607523_0033 served on January 4, 2018, with a compliance date of January 31, 2018. The inspector found that the licensee failed to ensure that the written record for the annual evaluation of the Responsive Behaviours Program included the date the evaluation was completed, the names of the persons who participated in the evaluation, and a summary of the changes made and the date that those changes were implemented.

  A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to:

  a) develop and implement a documented procedure in the home to ensure that the evaluation of the Responsive Behaviours program is completed in accordance with legislation,

  b) ensure that the written record of Responsive Behaviours program evaluation that was completed in response to compliance order from inspection 2017_607523_0033 served on January 4, 2018, with a compliance date of January 31, 2018, is updated to include: 1) the date the evaluation was completed, 2) the full names and signatures of the persons who participated in the evaluation and the dates when they participated, 3) a summary of the changes made to the program and the date that those changes were implemented.

- Regulation s. 53 (4), The licensee failed to ensure that, for each resident demonstrating responsive behaviours:

  (a) the behavioural triggers for the resident are identified, where possible;

  (b) strategies are developed and implemented to respond to these behaviours, where possible; and

  (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

  The inspector found that staff in the home did not identify the behavioural triggers for the resident, strategies were not developed and implemented to respond to these behaviours; and actions were not taken to respond to the needs of the resident, including reassessments, implementing interventions and documenting the resident's responses to interventions.

  A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to:

  a) Ensure there is a process developed and implemented for an identified resident and any other resident demonstrating responsive behaviours to ensure triggers for the resident are

identified and documented.

b) Ensure there is a process developed and implemented for an identified resident and any other resident demonstrating responsive behaviours to ensure strategies are developed and implemented to respond to these behaviours.

c) Ensure there is a process developed and implemented for identified residents and any other resident demonstrating responsive behaviours to ensure that for resident and any other resident demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including documented reassessments and consistent implementation of interventions. The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the interventions.

- Regulation s. 68. (2) (d), The licensee failed to ensure that the Nutrition Care and Hydration Programs included, the development and implementation of a system to monitor and evaluate the food and fluid intake of residents with identified risks. The inspector found that for a resident identified at high nutritional risk with weight loss, the resident was not referred to or assessed by the Registered Dietitian in the home regarding decreased intake, and that staff had not been consulted on the new policies and procedures in the home and did not have access to them at the time of the interview during the inspection. The policies and procedures did not provide direction for staff regarding the system in place to monitor and evaluation the food and fluid intake of residents.

  A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to:

  a) ensure that the Nutrition Care and Hydration Programs includes the development and implementation, in consultation with a Registered Dietitian who is a member of the staff of the home, of policies and procedures relating to a system to monitor and evaluate the food and fluid intake of an identified resident and any other resident with identified risks related to nutrition and hydration,

  b) ensure that all Personal Support Workers (PSWs), Registered Practical Nurses (RPNs) and Registered Nurses (RNs) are educated on the policies related to the system to monitor and evaluate the food and fluid intake of residents. The home must keep a documented record of the education provided.

- Regulation s. 73. (1)9, The licensee failed to ensure that the home had a dining and snack service that included food and fluids being served at a temperature that was both safe and palatable to the residents. The licensee failed to ensure that the home had a dining and snack service that included providing residents with the personal assistance and encouragement required to safely eat and drink as comfortable and independently as possible.

A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to ensure that the dining and snack services include providing identified residents with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

- Regulation s. 101. (3) The licensee failed to ensure that the documented record of complaints was reviewed and analyzed for trends at least quarterly, the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record was kept of each review and of the improvements made in response.

  A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to ensure that the home's documented record of complaints is reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in determining what improvements are required in the home; and a written record is kept of each review and of the improvements made in response which includes the documentation of the date of the review and the full names of the persons who completed the review.

- Regulation s. 116, The licensee failed to ensure that an interdisciplinary team including the Medical Director, Administrator, pharmacy service provider and a Registered Dietitian who was a member of the staff of the home met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. The quarterly evaluations in the previous year were not reviewed as part of the annual medication program evaluation.

  A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to:

  a) develop and implement a documented procedure in the home to ensure that the evaluation of medication management system is completed in accordance with the LTCHA.

  b) ensure there is a follow-up to the evaluation of the medication management system program evaluation that was completed in the home on January 29. 2018. This follow-up meeting must be a meeting that includes the Medical Director, the Administrator, the Director of Nursing, the pharmacy service provider and a RD who was a member of the staff of the home. During this meeting the following must be completed: 1) an evaluation of the effectiveness of the medication management system in the home and recommendation made on any changes necessary to improve the system, 2) a review of the quarterly evaluation from the previous year, 3) a documented record of the meeting which includes the date of the meeting, the full names and signatures of the persons who participated, a summary of what was completed as part of the evaluation and a summary of the

recommendations for improvement.

- Regulation s. 130. (3), The licensee of a long-term care home failed to ensure that steps are taken to ensure the security of the drug supply including a monthly audit was not undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action was taken if any discrepancies discovered.

  A compliance order was served on the licensee pursuant to section 153(1) (a) ordering the licensee to ensure a monthly audit is completed of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered.

- Regulation s. 131. (1), The licensee of a long-term care home failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

  A compliance order was served on the licensee pursuant to section 153(1) (a) ordering the licensee to ensure that no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident.

- Regulation s. 131. (2), The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

  A compliance order was served on the licensee pursuant to section 153(1) (a) ordering the licensee to ensure that drugs are administered to residents in accordance with the directions for use specified by the physician.

- Regulation s. 131. (3), The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. The inspector found that the home's Medication Incident Reports from December 2017 and January 2018 were reviewed as a part of the most recent quarterly review on March 8, 2018, noting medication incidents occurred where residents were administered a medication that had not been prescribed for them; and medications prescribed for residents to be administered were not given to the residents in accordance with the directions for use specified by the prescriber, and the licensee failed to ensure that Personal Support Workers were not administering a drug to a resident in the home unless that person was a registered nurse or a registered practical nurse.

  A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

- Regulation s. 135. (1) (b), (2), (3), The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was 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. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything; and that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record was kept of everything.

A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to a) ensure that every medication incident involving a resident and every adverse drug reaction is 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 nurses in the extended class attending the resident and the pharmacy service provider, b) ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective actions are taken as necessary and a written record is kept of everything.

- Regulation s. 229. (5) (b), The licensee failed to ensure that on every shift the symptoms indicating the presence of infection were recorded and immediate action was taken to respond to the presence of infection in each resident during the respiratory outbreak in March 2018.

  A compliance order was served on the licensee pursuant to section 153(1)(a) ordering the licensee to:

  a) review and revise the home's Infection Prevention and Control (IPAC) program policies related to outbreak management to ensure it provides clear direction to staff on the procedure for recording symptoms indicating the presence of infection on each shift,

  b) ensure that the leadership team, all Registered Nurses (RNs) and all Registered Practical Nurses (RPNs) working in the home are re-educated on the Infection Prevention and Control program policies and strategies related to outbreaks. The home must keep a documented record of the education provided.

  c) Implement the revised IPAC policies related to outbreak management to ensure that on every shift the symptoms indicating the presence of infection are recorded and immediate action is taken as required.

- LTCHA s. 22. (1), The licensee failed to immediately forward any written complaints that had been received concerning the care of a resident or the operation of the home to the Director. This was issued as a written notification and voluntary plan of correction.

- LTCHA s. 23. (1) (a), (2), The licensee failed to ensure that every alleged, suspected or witnessed incident of, neglect of a resident by the licensee or staff, that the licensee knows of, or that was reported was immediately investigated, and failed to ensure that the results of the abuse investigation were reported to the Director. This was issued as a written notification and voluntary plan of correction.

- LTCHA s. 33. (3), The licensee failed to ensure that a Personal Assistance Services Device (PASD) was used to assist a resident with a routine actively of living only if the use of the PASD was included in the residents plan of care. This was issued as a written notification and voluntary plan of correction.

- Regulation s. 36, The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents. This was issued as a written notification and voluntary plan of correction.

- Regulation s. 50. (2) (b) (i), The licensee failed to ensure that when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. This was issued as a written notification and voluntary plan of correction.

- Regulation s. 99, The licensee failed to ensure that there was an analysis of every incident of abuse or neglect of a resident at the home which was undertaken promptly after the licensee becomes aware of it that the results of the analysis of incidents of abuse were considered in the evaluation of the effectiveness of the policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents; that the changes and improvements under from the evaluation were promptly implemented and that there was a written record promptly prepared which included the date that the changes and improvements were implemented. This was issued as a written notification and voluntary plan of correction.

- Regulation s. 110. (2) 4, The licensee failed to ensure that when a resident was being restrained by a physical device under section 31 of the Act that the resident was released from the physical device at least once every two hours. This was issued as a written notification and voluntary plan of correction.

- Regulation s. 129. (1), The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked, and controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. This was issued as a written notification and voluntary plan of correction.

- Regulation s. 133, The licensee failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the signature of the person placing the order was recorded in respect of every drug that was ordered and received in the home. This was issued as a written notification and voluntary plan of correction.

- Regulation s. 72 (3) (a), The licensee failed to ensure that all food and fluids in the food production system were prepared and served using methods to preserve taste, nutritive value, appearance and food quality. This was issued as a written notification.

- Regulation s. 97. (2), The licensee failed to ensure that the resident's substitute decision-maker was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. This was issued as a written notification and voluntary plan of correction. This was issued as a written notification.

- Regulation s. 104. (1) 3, The licensee failed to ensure that when making a report to the Director under subsection 23 (2) of the Act, the following material was included 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: 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; actions taken in response to the incident, including, whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and the outcome or current status of the individuals who were involved. This was issued as a written notification.

- Regulation s. 241 (5), The licensee failed to ensure that there were policies and procedures of the management of trust accounts and the petty cash trust money that included the hours when the resident or persons acting on behalf of the resident could make deposits or withdrawals from the funds in a trust account and from petty cash trust money. This was issued as a written notification.

Grounds to Believe that the Licensee cannot or will not properly manage the home

The licensee has an extensive history of non-compliance with requirements under the LTCHA. This includes the licensee receiving multiple compliance orders that have been re-issued on follow-up inspections.

During an inspection in March 2016, the licensee was issued 37 written notifications, 22 voluntary plans of correction, 16 compliance orders and 2 Director referrals. The Director referrals were made following the fourth re-issue of a compliance order related to the quality improvement

program in the home as well as the third re-issue of a compliance order related to the home's complaint's process. During this inspection, there were also concerns identified with the stability of the management team in the home as the licensee was not able to provide a strategic plan related to the management of the home.

At the time, based on the significant number of findings of non-compliance, the Director believed that there was a risk of harm to the health or well-being of residents. This led to the first cease of admissions at the home on March 14, 2016. On July 27, 2016 the cease of admissions was lifted after all 16 compliance orders were complied. Over the next year, there were 15 different inspections conducted at the home where no compliance orders were issued.

During an inspection conducted in August 2017, the licensee was issued several findings of non-compliance, which included 5 compliance orders and a Director's referral. The Director's referral was related to the home's written staffing plan as it was not consistent with the residents' assessed care and safety needs. During this inspection, there was also significant turnover in management that was identified:

- The Director of Care (DOC) was on leave for three weeks in August and coverage for the position was provided by a Registered Nurse (RN) whose qualifications did not meet the requirements under the LTCHA to be a Director of Nursing and Personal Care.
- A new Director of Dietary Services was hired just prior to the inspection.
- The Director of Recreation position became vacant during the inspection period.
- Two Assistant Director of Care (ADOCs) positions have been vacant since April 2017 with no replacements at the time of the inspection.
- A new Business Manager was hired and was receiving orientation at the time of the inspection. Interviews with staff indicated that this position had been vacant since April, 2017, causing a significant increase in workload on other managers 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. Following the inspection and referral to the Director, the Director believed that there was a risk of harm to the health or well-being of residents in the home. This led to a Director's Order and the second cease of admissions at the home on October 3, 2017, which remains in effect.

During the most recent inspection in March 2018, the licensee was issued 31 written notifications, 9 voluntary plans of correction, 20 compliance orders and 2 Director referrals. There was a failure to comply with 7 out of 8 previously issued compliance orders. The Director referrals were related to the second re-issuance of a compliance order related to the written staffing plan as it was not

consistent with the resident's care and safety needs as well as the licensee's failure to comply with the Director's Order issued in December 2017. The inspectors found that the home's staffing plan placed the residents at risk for potential harm due to delayed response times to residents' care needs, pain management, bladder and bowel continence care, skin and wound needs, repositioning and assistance with eating. During this inspection there were concerns identified with actual harm to a resident related to the falls prevention program in the home as well as risk of potential harm related to the infection prevention and control program. During this inspection period, coverage for the DOC position was provided by a member of the consultant group. Recruitment for a DOC position, vacant since December 2017, was in progress; however, the consultant group reported that they were having difficulties recruiting and indicated that their goal was to fill the position by June 2018. The Assistant Director of Care (ADOC) started in December 2017 and was reported to be in the role on a trial basis. The consultant group reported that the Resident Care Coordinator position would be eliminated at the end of April 2018 with no replacement planned. The Food Services Manager position became vacant in April, 2018, with no replacement at the time of this inspection.

The extensive history of non-compliance at the home demonstrates that despite being issued various written notifications and compliance orders, many of which have been re-issued multiple times, the licensee repeatedly fails to ensure its compliance with requirements under the LTCHA and achieve compliance through identifying and implementing corrective actions. The home's management instability and lack of leadership have not enabled the home to properly identify and implement any corrective action to address non-compliance. Based on interviews, record reviews and observations, the management of the home did not make the changes required to meet the needs of the residents and achieve compliance between August 2017 and March 2018. During the March 2018 inspection, the inspectors found that the leadership in the home lacked the corporate support, resources and expertise required to effectively manage the home.

Summary:

The Director is issuing this Mandatory Management Order as the licensee has had an ongoing failure to comply with numerous requirements in the LTCHA and the Regulation, which provide the Director with reasonable grounds to believe that the licensee cannot or will not properly manage the long-term care home.

This decision is based on the ongoing non-compliance with the LTCHA and Regulations, including the re-issue of multiple compliance orders and non-compliance with Director's orders. The licensee has demonstrated that even with the assistance of external consulting companies, it continues to fail to comply with requirements under the LTCHA and the leadership in the home is unable to properly identify and implement corrective actions to address non-compliance.

Based on the licensee's repeated and ongoing failure to ensure the home complies with the LTCHA and the Regulation, the risk of potential harm to residents, the instability of the

long-term care home's management team, the licensee's failure to comply with inspector and Director's Orders, and the cease of admissions twice in an 18 month period since 2016, I have reasonable grounds to believe that the licensee cannot properly manage the LTC home.

This order must be complied with by:	The dates as outlined and specified in the Order.

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

Issued on this 28th day of May, 2018	
Signature of Director:	Stacey Colameco
Name of Director:	Stacey Colameco