Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2019	2019_605213_0028	016481-19, 016684-19	Complaint

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

Long-Term Care Home/Foyer de soins de longue durée

Earls Court Village
1390 Highbury Avenue North LONDON ON N5Y 0B6

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

RHONDA KUKOLY (213), CHRISTINA LEGOUFFE (730)

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): September 5, 6, 9, 10, 11, 12, 2019

The following were completed during this inspection:
Log #016481-19, Infoline #IL-69544-LO and #IL-69582-LO, a complaint related to a missing resident
Log #016684-19, Critical Incident #3047-000015-19, related to a missing resident

During the course of the inspection, the inspector(s) spoke with the Nurse Consultant, Senior Nurse Consultant , Vice President of Operations and Vice President of Finance from Responsive Health Management, the Administrator, the Acting Director of Care, the Office Manager, the Director of Facilities Services, the Director of Therapeutic Recreation, the Resident Assessment Instrument Coordinator, the Behaviour Supports Ontario Registered Practical Nurse, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.

The Inspectors also made observations and reviewed health records, training records, policies and procedures, meeting minutes, reports, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Family Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	Légende 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. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Family Council advised the licensee of concerns or recommendations related to the operation of the home, the licensee responded to the Family Council, in writing, within 10 days of receiving the advice.

The Ministry of Long-Term Care (MLTC) received a complaint on August21, 2019, which included concerns related to the Family Council in the home.

During an interview with Family Council Co-Chair , they stated that during the August 2019 meeting there had been some concerns raised by the council related to annual care conferences. Family Council Co-Chair stated that some of the issues raised at the August 2019 meeting had been brought up several times. They said that the Family Council did not receive written responses and were not aware that the home could provide them with a written response. They said the home usually got back to them at the next month's meeting.

Inspector #730 reviewed the Family Council meeting minutes from November 2018 to August 2019. Annual care conferences were noted as a concern with a request in the meeting minutes in November 2018, and January, February, May, June, and August 2019. The May 2019 meeting minutes stated that a member of the Family Council requested a formal procedure regarding the meeting format, scheduling, etc. for the annual care conferences and that Executive Director (ED) would follow-up at the June meeting. The June 2019 meeting minutes stated that the home could not provide an exact answer to the request regarding the annual care conferences, as the Assistant Director of Care (ADOC) was on a leave at that time. The August 2019 meeting minutes showed that the Family Council asked again for a more formal procedure for the annual care conferences. No written responses were found from the home to the Family Council related to any of the meeting minutes reviewed by inspector #730.

During an interview with the ED, they stated that they attended most of the Family Council meetings, as they were always invited. They said that concerns brought up by the Family Council would be documented on a Client Service Response (CSR) form. They said that they did not believe that any CSR forms had ever been filled out by Family Council. They said that management addressed concerns during the Family Council meetings and the responses were documented in the meeting minutes. The ED said that if the management was not able to address a concern during a meeting that a CSR form would be filled out or they would circle back to the concern at the next meeting.

During a second interview with the ED, they said that regarding the concern related to

the annual care conferences brought up at the May meeting, that the home did not follow up with a written response within ten days. The ED said that the home was currently working on a response and that it remained a challenge. The ED said that this continued to be a concern of the Family Council as the Family Council wanted a very succinct agenda for the annual care conferences and they felt that developing an agenda might restrict what the conference was supposed to be about. They acknowledged that the concern had been raised at many of the Family Council meetings over the last year.

The licensee has failed to ensure that when the Family Council had concerns regarding the annual care conferences, the licensee responded, in writing, within 10 days. [s. 60. (2)]

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 when the Family Council advised the licensee of concerns or recommendations related to the operation of the home, the licensee responds to the Family Council, in writing, within 10 days of receiving the advice, 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The following is additional evidence to support Compliance Order #007 identified in complaint inspection #2019_736689_0024 with a compliance date of November 29, 2019.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an elopement from the home by a resident. MLTC also received a complaint related to the care of the same resident. The complainant stated that on an identified date they had arrived at the home and could not find the resident, so they alerted staff that the resident was missing.

A review of the resident's plan of care in Point Click Care (PCC), showed a focus of potential for elopement/exit seeking with identified interventions.

Review of a documentation report from PCC for the resident showed no documentation for 6 of 140 (four per cent) of one of the interventions for an 18 day time period. For another intervention, there was no documentation for 9 of 33 (27 per cent) for an 11 day period of time.

During an interview with a PSW they stated that the resident had interventions in place related to exit seeking. The PSW stated that there were two instances that they knew of where the resident had eloped from the building. They said that they documented completion of interventions in Point of Care (POC). The Inspector reviewed the documentation report with the PSW, and they stated that it did not meet the home's expectations for documentation. They stated that everything needed to be charted.

The licensee has failed to ensure that provision of the care set out in the plan of care for resident was documented. [s. 6. (9)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, every alleged, suspected or witnessed incident that the license knew of, or that was reported to the licensee, was immediately investigated and appropriate action was taken in response to every such incident, for anything else provided for in the regulation.

The following is additional evidence to support Compliance Order #008 identified in complaint inspection #2019_736689_0024 with a compliance date of November 1, 2019.

Ontario Regulation 79/10 s. 107 (3) 2 states that every licensee of a long-term care home shall ensure that the Director is informed, no later than one business day, of a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition, followed by the report.

Specifically, the licensee has failed to ensure that the incident that the licensee knew of, related to the elopement of a resident, was investigated.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an elopement from the home by a resident. The MLTC also received a complaint related to the care of the same resident. The complainant stated that resident had been living in the home for a short period of time and had been able to exit the home on occasions prior to the one identified in the critical incident report. They said that they had been the one to notice that the resident was missing from the home. They said that

they had arrived, could not find the resident, and alerted staff that the resident was missing. They stated that they left the home to look for the resident and called the police. They said the resident was found by the police approximately half a kilometer from the home.

A review of the progress notes in Point Click Care (PCC) for the resident, which stated that the resident's family member had been in to the home and had not been able to find the resident. The note stated that a code yellow was initiated, the Executive Director (ED) was notified, and the police were informed of the missing resident. A progress note said that the resident had been found by police and returned to the home by the family member and a head to toe assessment had been completed with no injuries noted.

A Client Service Request (CSR) form stated that the ED had received a verbal complaint related to an elopement for a resident. The section of the CSR form titled "action taken and outcome" said that the ED met with the Power of Attorney (POA) to review the concern, a one to one staff member was put in place, and the door alarm system checked. The door system was found to be in working order. The section of the CSR form titled "response to complainant/complainant response," said that the one to one staff member was discontinued as the resident had not attempted to exit seek and there was a meeting set to discuss the next steps with the POA. The "final resolution" portion of the form was not completed.

Inspectors #730 and #213 observed the resident attempting to exit seek from the home on two different dates and times.

During an interview with a Personal Support Worker (PSW), they stated that resident had interventions in place related to exit seeking. The PSW stated that there were two instances that they knew of where the resident had eloped from the building. They said that they were working at the time when the resident eloped from the building. They said that the resident had continued to attempt to elope from the building.

During an interview with the ED, they said that they had been made aware of the elopement by a Registered Nurse (RN). When asked about the home's investigation of the incident, the ED said that they completed the investigation with Director of Facility Services. They said that they looked at how the resident "beat" the door alarm system and had discussions with the POA. The ED said that they were unsure what interventions were supposed to be in place or were in place at the time when the resident eloped. They said that they did not interview staff as a part of the investigation and there was no

documentation of the investigation. The ED also said that they were unaware that the resident had previously eloped from the home.

The licensee failed to immediately investigate the elopement of resident from the home. [s. 23. (1)]

Issued on this 26th day of September, 2019

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

Original report signed by the inspector.