

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report	
Report Issue Date: July 13, 2023	
Inspection Number: 2023-1225-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Sharon Farms & Enterprises Limited	
Long Term Care Home and City: Kensington Village, London	
Lead Inspector Christie Birch (740898)	Inspector Digital Signature
Additional Inspector(s) Tatiana Pyper (733564) Kristen Murray (731)	

INSPECTION SUMMARY
<p>The inspection occurred onsite on the following date(s): June 20, 21, 22, 23, 26, 27, 28, 2023.</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> Intake: #00089991 - Proactive Compliance Inspection

The following **Inspection Protocols** were used during this inspection:

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Medication Management
- Food, Nutrition and Hydration
- Residents' and Family Councils
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Quality Improvement

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Pain Management
Falls Prevention and Management

INSPECTION RESULTS

IMMEDIATE COMPLIANCE ORDER [ICO #901] AIR CONDITIONING REQUIREMENTS

NC #001 Immediate Compliance Order (ICO)

O. Reg. 246/22, s. 23.1 (1) 1., served on June 20, 2023 within inspection # 2023-1225-0002.

Please refer to inspection 2023-1225-0003 for ICO follow up results.

IMMEDIATE COMPLIANCE ORDER [ICO #902] AIR CONDITIONING REQUIREMENTS

NC #002 Immediate Compliance Order (ICO)

O. Reg. 246/22, s. 23.1 (3) 1., served on June 21, 2023 within inspection # 2023-1225-0002.

Please refer to inspection 2023-1225-0003 for Immediate Compliance Order (ICO) follow up results.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that the provision of care set out in the plans of care were documented.

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Rationale and Summary

Care for residents was not documented for activities of daily living (ADLs).

The Personal Support Worker (PSW) stated that care was provided to the residents, however, it was not documented. The Director of Care (DOC) stated that resident care should have been documented.

There was minimal risk to the residents related to the care not being documented.

Sources: Clinical records, including plan of care, and care records; and interviews with staff. [731]

WRITTEN NOTIFICATION: Obstruction

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 153 (a)

The Licensee has failed to ensure that every person does not hinder, obstruct or interfere with or attempt to hinder, obstruct or interfere with an inspector conducting an inspection.

Rationale and Summary

During a proactive compliance inspection, a staff member was interviewed in relation to the completion of required tasks. The staff member produced a document that was printed on the day of the interview but signed in ink on a date prior by another staff member. When this staff member that signed the document was interviewed they admitted to not completing the task they had signed for and that they were asked to complete the document on that day by a different staff member and provide to the inspectors.

During a subsequent interview and follow up email, the first staff member interviewed admitted that they asked the other staff member to complete the document on that day and date it for a previous date.

The two staff collaborated and brought false documents to the inspector, then later identified that the documents were false during an interview; this hindered the inspectors in identifying truthful information during their inspection.

Sources: Interview with staff members, record review of documents [740898]

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

The Licensee has failed to ensure that the infection prevention and control lead works regularly in that position on site at the home for at least 26.25 hours per week.

Rationale and Summary

Section 102 (15) 2 of the Ontario Regulation 246/22 specified a home with a licensed bed capacity of more than 69 beds but less than 200 beds, must have an IPAC lead on site at least 26.25 hours per week.. The home had 78 licensed beds and therefore met the 26.25 hours per week requirement.

The Director of Care (DOC) confirmed being both the DOC and the IPAC lead since the beginning of May 2023. They could not attest that they had spent the minimum of 26.25 hours per week requirement in their IPAC Lead role.

During this IPAC inspection of the home, there is no indication that this had a negative impact of the safety of the residents.

Sources: Interview with Director of Care/IPAC Lead [740898]



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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