Ontario

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

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

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

Original Public Report

Report Issue Date: May 13, 2024	
Inspection Number: 2024-1225-0002	
Inspection Type: Critical Incident	
Licensee: Sharon Farms & Enterprises Limited	
Long Term Care Home and City: Kensington Village, London	
Lead Inspector Loma Puckerin (705241)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8, 9, 10, 2024

The following intake(s) were inspected:

- Intake: #00108091 related to verbal and emotional abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (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,

The licensee has failed to ensure that an incident of alleged abuse to a resident was immediately investigated.

Rationale and Summary
The home submitted Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to resident-to-resident alleged abuse.

The home's policy " Zero Tolerance of Abuse & Neglect " stated any reported abuse will be immediately investigated.

The home’s documentation of the investigation conducted related to the incident was requested. The home was unable to provide the investigation documents.

The Executive Director (E.D) stated an investigation of the incident was not conducted.

The home’s failure to investigate the incident posed an increased risk that

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allegations of abuse to residents would not be addressed and investigated.

Sources: Review of CIS report, the home's "Zero Tolerance of Abuse & Neglect" policy revised March 2024, and an interview with the E.D.

[705241]