

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007 Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division Performance Improvement and Compliance Branch Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la

conformité

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#### Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 17, 18, 30, Feb 6, 15, 16, Mar 6, 2012	2012_090172_0003	Critical Incident
Licensee/Titulaire de permis		
SHARON FARMS & ENTERPRISES LI 1340 HURON STREET, LONDON, ON	, N5V-3R3	TANKS AND A STATE OF THE STATE
Long-Term Care Home/Foyer de soir	is de longue durée	
KENSINGTON VILLAGE  1340 HURON STREET, LONDON, ON	, N5V-3R3	
Name of Inspector(s)/Nom de l'inspe	cteur ou des inspecteurs	
JOAN WOODLEY (172)		
Ins	spection Summary/Résumé de l'inspe	ection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator and the Assistant Director of Care, 1 Registered Nurse, 1 Registered Practical Nurse, 3 Personal Support Workers and 1 Dietary Aide.

During the course of the inspection, the inspector(s) held interviews.

The following Inspection Protocols were used during this inspection: Falls Prevention

Medication

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

### NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
LTCHA includes the requirements contained in the items listed in	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following subsections:

- s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
- (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
- (b) corrective action is taken as necessary; and
- (c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

# Findings/Faits saillants:

1. Staff interview with Administrator and the Assistant Director of Care revealed the home has not been in contact with the family of resident, related to the disclosure of a medication incident, as part of the corrective action taken by the home, when reviewing their processes.

[LTCHA, 2007,S.O.2007, c.8,s.135(2)(b)]

# 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 be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

#### Findings/Faits saillants:

- 1. Staff Interview with Administrator and Assistant Director of Care confirmed an incident of physical abuse to a resident by a non-staff person.
- [LTCHA, 2007, S.O.2007, c.8, s.19(1)]
- 2. Staff Interview with Administrator and Assistant Director of Care confirmed a Personal Support Worker spoke inappropriately to a resident.

[LTCHA, 2007, S.O.2007, c.8, s. 19(1)]



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Issued on this 6th day of March, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteu	irs
Joan L. Shodley	