Ontario

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

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

**London District**
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## Original Public Report

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| **Report Issue Date:** May 31, 2024 |
| **Inspection Number:** 2024-1225-0003 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** Sharon Farms & Enterprises Limited |
| **Long Term Care Home and City:** Kensington Village, London |

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29, 30, 2024

The following intake(s) were inspected:

- Intake: #00114781 - CI 2729-000006-24 Fall of resident resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Required programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**
Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure that the Falls Prevention and Management program was implemented, specifically, the Head Injury Routine (HIR) completed as per home's policy.

**Rationale and Summary**
In accordance with O Reg. 246/22 s. 11 (1) b, the licensee was required to ensure that written policies and protocols for the falls prevention and management program were developed and complied with. Specifically, staff did not comply with the home's "Head Injury Routine" policy.

A critical incident (CI) was received related to an unwitnessed fall of a resident.

The home's policy titled, Head Injury Routine (HIR), as part of the home's Falls Prevention and Management program, noted the following:
- "HIR will be initiated for all falls that are not witnessed, and for witnessed falls that include the possibility of a head injury as defined above"
- "HIR during sleeping hours: resident will have HIR during the late evening an during the night for at least 72 hours unless otherwise specified by the MD/NP"
- "Frequency of observation to be as follows unless otherwise determined by Physician/NP: Q15 minutes x 4 (1 Hr), Q 1/2 Hr x 4 (2 hours), QIHr x 4 (4 hours), Q8 Hr x 8 (72 hours)."

The Head Injury Assessment form for this resident's fall noted that all required assessments were not completed in full.

The Director of Care (DOC) acknowledged that the HIR for this resident was not completed as per home's policy.

There was risk to this resident of symptoms of a head injury not being detected when the HIR was not completed as per policy.

**Sources:** Review of Critical Incident System (CIS), the home's policy titled "Head Injury Routine (HIR) Policy", NAM-E-65 last revised September 2021, resident's clinical records and interview with the DOC [740898]