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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London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: November 14, 2025
Inspection Number: 2025-1225-0004
Inspection Type: Proactive Compliance Inspection
Licensee: Sharon Farms & Enterprises Limited
Long Term Care Home and City: Kensington Village, London

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 4-7, 10, and 12-14, 2025.

The following intakes was inspected:

- Intake: #00161524 - Proactive Compliance Inspection (PCI)

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

Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (a)
Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;

A resident had a focus and goals in their care plan related to an area of altered skin integrity that had been resolved for six months. The care plan was not reviewed and revised when the goal in their care plan was met. The home updated the care plan during the course of the inspection.

Sources: The home's Skin and Wound-Prevention & Management Program policy; resident's clinical records, including care plan, and assessments; and staff interviews.

Date Remedy Implemented: November 10, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The home's policy related to the use of a specific medical device indicated that before implementing this medical device, an order from the Physician or Nurse Practitioner was to be obtained, written in the resident's clinical record and entered on their Treatment Administration Record (TAR), including the directions for use, reason for use, and frequency of replacement. Personal Support Workers (PSWs) were also directed to provide specific care related to this medical device on each shift, monitor at least twice daily for concerns related to the use of this medical device, and document and report any concerns to registered staff.

A resident had this medical device implemented and there was a handwritten order from their physician which directed staff to implement the medical device.

There was no order entered on their TAR related to this medical device, or documented direction related to the frequency of replacement until 19 days later.

PSW staff said they would refer to a residents kardex and scheduled tasks on Point of Care (POC) to find information related to a resident's specific care needs and they would document on the care they provide to residents in POC.

The resident's care plan and kardex was not updated to reflect that they had this medical device in place until six days after it was implemented, and did not provide specific direction to staff on providing care related to this medical device or monitoring and reporting concerns identified. Additionally, the resident did not have any scheduled tasks on POC for PSW staff to document on the care they provided to the resident related to this medical device or concerns identified.

The resident's plan of care did not provide clear direction to staff related to this medical device.

Sources: Sharon Village Care Homes policy; the resident's clinical record, including progress notes, written physician's orders, TAR, care plan, and POC tasks; and staff interviews.

WRITTEN NOTIFICATION: Integration of Assessments, Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A resident had a head-to-toe assessment completed which did not document a previously identified area of altered skin integrity on the resident. This head-to-toe assessment was not consistent with other skin and wound assessments for the resident, which indicated they had this area of altered skin integrity.

Sources: The home's Skin and Wound-Prevention & Management Program policy; resident's clinical records, including progress notes, and assessments; and staff interviews.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The home's Bowel and Bladder Continence Care Program Implementation policy directed staff to complete a continence assessment for residents when they had a significant change in their continence status. Staff were also directed to update a resident's plan of care with any significant change in health status.

A resident experienced a significant change in their bladder continence status. A continence assessment was completed for the resident when they were admitted to the home approximately seven months prior, and there was no subsequent continence assessment initiated until 17 days after they experienced this change in their bladder continence status. Additionally, their care plan was not updated to reflect this change in their bladder continence status until six days after they experienced the change.

The resident was not immediately reassessed and their plan of care was not immediately reviewed and revised when they experienced a significant change in their bladder continence status.

Sources: Sharon Village Care Homes policy titled "Bowel and Bladder Continence Care Program Implementation"; the resident's clinical record, including progress notes, care plan, and assessments; and staff interviews.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

A resident had a pressure injury identified, and this area of altered skin integrity was not reassessed until 27 days later, during which time it had deteriorated. After this date, there was an additional period of 13 days and period of 12 days where weekly reassessments of this area of altered skin were not completed. Five out of nine weekly skin assessments were not completed.

Sources: The home's Skin and Wound-Prevention & Management Program policy; the resident's clinical records, including progress notes, and assessments; and staff interviews.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 5.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

An annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff had not been conducted in the past year.

Sources: emails and staff interviews.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The home's Bowel and Bladder Continence Care Program Implementation policy directed staff to complete a continence assessment for residents on admission, readmission and when a change of condition occurs which has bowel incontinence as a symptom. Staff were to update the resident's plan of care to reflect the assessment, type of incontinence and individualized interventions.

A resident was admitted to the home at which time it was identified that they were continent of bowel. A continence assessment was completed on this date; however it focused on urinary incontinence and did not assess them for bowel incontinence.

The resident's Resident Assessment Instrument (RAI) assessment, care plan, and POC task documentation indicated they were incontinent of bowel after their admission to the home.

There were no continence assessments completed for the resident to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions, when it was identified they were incontinent of bowel after their admission to the home.

Sources: Sharon Village Care Homes policy titled "Bowel and Bladder Continence Care Program Implementation"; the resident's clinical record, including care plan, assessments; RAI and tasks; and staff interviews.

COMPLIANCE ORDER CO #001 Plan of care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 29 (3) 8.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Ensure that all members of the registered nursing team are retrained on the home's policies and expectations for assessing a resident's bladder and bowel continence status, including constipation and reviewing and revising resident's plans of care. A record must be kept of the date the training was provided, who attended the training, the contents of the training, and who provided the training.
B) Develop and implement a process for completing weekly audits for two different resident's in the home to ensure that interdisciplinary assessments of the resident's bladder and bowel continence status, including constipation are being completed and plans of care are being reviewed and revised in accordance with the homes policies. A documented record must be maintained of the audits completed, which includes the date of the audit, the person who conducted the audit, the resident audited, information reviewed as part of the audit, any inconsistencies with the home's policies identified, and any corrective actions taken as a result of the audit. These audits must continue until this compliance order is complied by an inspector.

Grounds

1.The home’s Bowel and Bladder Continence Care Program Implementation policy directed staff to develop an individualized bowel plan of care to support the assessed needs of each resident, and to complete a continence assessment for residents on admission, readmission and when they had a significant change in their continence status.

A continence assessment was completed for a resident when they were admitted to the home which indicated they were incontinent of bowel and specific interventions were to be implemented for them. The resident’s clinical record documented changes in their bowel continence status since their admission to the home, however there were no subsequent continence assessments completed.

The resident's care plan indicated they were continent of bowel, and their plan of care was not based on an interdisciplinary assessment of their bowel continence care needs.

Sources: Sharon Village Care Homes policy titled "Bowel and Bladder Continence Care Program Implementation"; the resident's clinical record, including progress notes, care plan, RAI, assessments and tasks; and staff interviews.

2.The home's Bowel and Bladder Care Program Implementation policy directed staff to develop an individualized bowel plan of care to support the assessed needs of each resident, and specifically to complete a bowel record, followed by an assessment of continence and constipation for residents on admission, readmission and when a significant change occurs. It was also stated in this policy that effective care of continence and constipation is based on a thorough assessment, accurate identification of the causative and contributing factors and implementation and evaluation of a comprehensive, interdisciplinary plan of care.

It was identified on a resident's admission to the home that they had a history of constipation and since their admission to the home, they had been administered medication related to constipation on multiple occurrences.

An assessment of continence and constipation was initiated for them on admission to the home, however constipation was not assessed as part of this. There were no subsequent assessments of continence and constipation completed for them and their care plan did not include any specific direction related to constipation.

The resident's plan of care was not based on an interdisciplinary assessment of continence, including bowel elimination.

Sources: Sharon Village Care Homes policy titled "Bowel and Bladder Continence Care Program Implementation"; the resident's clinical record, including diagnosis, progress notes, Medication Administration Record (MAR), medical directives, care plan, and assessments; and staff interviews.

This order must be complied with by December 30, 2025

COMPLIANCE ORDER CO #002 Skin and wound care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Ensure the two identified resident's receive skin assessments using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for their areas of altered skin integrity.
B) Review the home's policy related to skin and wound assessments. Upon completion of the review, update the policy, as needed. Maintain a documented record of the review including who participated in the review, the date the review occurred, and any changes made to the policy.
C) Retrain all registered nursing staff on the the home's policy related to skin and wound assessments including types of altered skin integrity and where to document the assessments. Keep a documented record of the attendees, materials covered, the date(s) the training occurred, and who provided the training.
D) Complete weekly audits for two different residents each week, to ensure skin and wound assessments are completed as required. Keep a documented record of the residents audited, date the audits were completed, who completed the audits, any deficiencies noted, and any actions taken to address the deficiencies. The audits must continue until the order is complied.

Grounds

1. A resident had two areas of altered skin integrity, and they did not receive a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment for either area of altered skin integrity.

2. A resident had multiple areas of altered skin integrity, and they did not receive a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment for the areas of altered skin integrity.

Sources: The home's Skin and Wound-Prevention & Management Program policy; the resident's clinical records, including progress notes, TAR, and assessments; and staff interviews.

This order must be complied with by December 30, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.