



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2017	2017_263524_0014	015693-16, 016639-16, 017820-16, 019419-16, 022027-16, 022654-16, 023016-16, 023548-16, 024859-16, 026872-16, 028455-16, 031535-16, 032013-16, 033027-16, 034025-16, 002707-17, 003064-17, 006602-17	Critical Incident System

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

Long-Term Care Home/Foyer de soins de longue durée

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

INA REYNOLDS (524), JENNA BAYSAROWICH (667), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 5-9, 12-16, 2017.



The following Critical Incident inspections were conducted:

Related to prevention of abuse:

**Log # 015693-16, CI 3047-000028-16
Log # 016639-16, CI 3047-000040-16
Log # 017820-16, CI 3047-000048-16
Log # 019419-16, CI 3047-000053-16
Log # 022027-16, CI 3047-000063-16
Log # 022654-16, CI 3047-000065-16
Log # 023016-16, CI 3047-000066-16
Log # 023548-16, CI 3047-000067-16
Log # 024859-16, CI 3047-000068-16
Log # 026872-16, CI 3047-000071-16
Log # 028455-16, CI 3047-000072-16
Log # 031535-16, CI 3047-000080-16
Log # 032013-16, CI 3047-000086-16
Log # 033027-16, CI 3047-000094-16
Log # 034025-16, CI 3047-000097-16
Log # 002707-17, CI 3047-000005-17
Log # 003064-17, CI 3047-000006-17
Log # 006602-17, CI 3047-000010-17**

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, the Environmental Manager, two physicians, four Registered Nurses, six Registered Practical Nurses, twelve Personal Support Workers, one Housekeeping Aide, one family member and residents.

During the course of the inspection, the inspector(s) also observed residents and the care provided to them, resident and staff interactions, medication administration, reviewed medical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, staff education and training records, reviewed relevant policies and procedures of the home and internal investigation notes.

The following Inspection Protocols were used during this inspection:



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**Continence Care and Bowel Management
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity.

Review of a Critical Incident report submitted by the home and progress notes showed that an identified resident filed a complaint to a registered nurse on a specific date, that a personal support worker had an inappropriate conversation with them in a disrespectful manner.

Record review showed that the home launched an internal investigation into the incident of inappropriate verbal conduct demeaning to a resident on a specific date. The home concluded that the incident in fact occurred and the Personal Support Worker (PSW) had contravened the resident's rights with respect to being treated with courtesy and respect. The PSW was terminated from employment on a specific date, due to a culmination of prior incidents of a similar nature and admission of unprofessional conduct as a result.

In an interview with the Administrator on June 12, 2017, it was acknowledged that the PSW had inappropriate conversations demeaning in nature with the resident and had not treated the resident with courtesy and respect.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal risk. The home had related non-compliance in the last three years. [s. 3. (1) 1.]

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 ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.



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Issued on this 13th day of July, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.