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

Original Public Report

Report Issue Date: December 3, 2024
Inspection Number: 2024-1475-0003
Inspection Type: Complaint Critical Incident
Licensee: Sharon Farms & Enterprises Limited
Long Term Care Home and City: Earls Court Village, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 21, 22, 25, 26, 2024

The following intake(s) were inspected:

- Intake: #00127603, Complaint related to a resident's responsive behaviours.
- Intake: #00128213, Complaint related to allegations of neglect.
- Intake: #00129358, CIS related to a resident's injury with unknown cause.
- Intake: #00129465, Complaint related to a resident's injuries with unknown cause.
- Intake: #00129945, Complaint related to a resident's falls prevention interventions.
- Intake: #00130971, Complaint related to food production and a resident's responsive behaviours.
- Intake: #00132005, Complaint related to a resident's foot care.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care Based on assessment of the resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in a resident's plan of care was based on an assessment of the resident and the needs of that resident.

Rationale and summary:
A review of a resident's plan of care showed there was no documentation to support identified care conditions, the goals of care or the interventions established to meet the resident's care needs.

When the resident's plan of care failed to document identified care requirements, it impacted the resident's right to receive care consistent with their needs and increased their risk of unidentified medical complications.

Sources: A complaint, resident clinical records, staff interviews.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rational and summary:
The Director received a complaint stating the resident did not have specific fall prevention interventions applied as specified in their plan.

A clinical record, and staff interview showed the resident had specific plan of care interventions. On a certain date those interventions were not provided to the resident as specified in their plan of care.

The ADOC said the expectation was for the staff to apply the chair and clip alarm as specified in the resident's plan of care.

sources: resident's clinical records and staff interview.

WRITTEN NOTIFICATION: Care conference

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,

(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure that a care conference was held at least annually to discuss a resident's plan of care and any other matters of importance to the resident and their substitute decision-maker.

Rationale and summary:
A review of a resident's clinical records showed there was no documentation of a Multidisciplinary Care Conference for the three identified years. This impacted the resident's right to an interdisciplinary review of their plan of care and increased their risk of unidentified health concerns.

Both the Assistant Director of Care (ADOC) and the Administrator said the care conference had not been completed annually and should have been to ensure an interdisciplinary approach was utilized to review the resident's plan of care, as legislated.

Sources: A complaint, resident clinical records, interviews with staff.

WRITTEN NOTIFICATION: Foot care and nail care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee has failed to ensure that a resident received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Rationale and summary:
A review of a resident's plan of care documented several assessments and pictures related to the resident's feet, which identified medical conditions requiring preventative and basic foot care services. The resident did not receive the required foot care services, which impacted the resident's right to receive care consistent with their needs and increased the resident's risk of infection, and discomfort.

Sources: Complaint, resident clinical records, 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) (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 licensee has failed to ensure that when a resident exhibited areas of altered skin integrity, that the resident received a skin assessment by an authorized person using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

Rational and summary:
A clinical record review for the resident documented multiple altered skin integrity concerns which were identified to registered staff. The registered staff did not follow-up with a skin and wound assessment as legislated.

When the resident did not receive skin and wound assessments it impacted the resident's right to receive care consistent with their needs and increased their risk of unidentified medical complications.

Sources: A complaint, resident clinical record review and staff interviews.