

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

Public Report

Report Issue Date: May 5, 2025

Inspection Number: 2025-1475-0002

Inspection Type:

Complaint
Critical Incident
Follow up

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): April 24, 25, 28, 29, and 30, 2025 and May 1, 2, and 5, 2025

The inspection occurred offsite on the following date(s): May 2, 2025

The following intake(s) were inspected:

- Intake: #00139994 – Critical Incident (CI) 3047-000004-25 related to Prevention of Abuse and Neglect
- Intake: #00141705 - Complaint related to Medication Administration and Resident Care
- Intake: #00142715 – Complaint related to Medication Administration and Resident Care
- Intake: #00144163 – Complaint related to Missing Resident
- Intake: #00145707 – Complaint related Medication Administration
- Intake: #00142214 - Follow-up Compliance Order (CO) #001 from Inspection 2025-1475-0001 related to O. Reg. 246/22, s. 61 (4) Palliative Care with a Compliance Due Date of April 16, 2025

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

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1475-0001 related to O. Reg. 246/22, s. 61 (4)

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

- Resident Care and Support Services
- Medication Management
- Safe and Secure Home
- Reporting and Complaints
- Palliative Care
- Admission, Absences and Discharge

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) (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.

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

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's transfer needs changed.

The care plan was not updated in all focus areas related to mobility after an assessment identified the resident's ability transfer ability changed. The Director of Care (DOC) verified the care plan was not revised when the resident's needs changed.

Sources: MLTC Complaint Intake, resident clinical record review of progress notes, Physiotherapy (PT) Assessment, and care plan; and interviews with the resident, and the DOC.

Date Remedy Implemented: April 29, 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 (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 failed to ensure that the care set out in the plan of care was based on an assessment of the resident and on the resident's request for a positioning device.

The Director of Care verified the care plan was not updated after an assessment identified the resident requested a positioning device. The assessment documented the resident's request and there was no follow up, there was no documentation as part of the clinical record that identified why the resident requested the device, or the intended use related to the resident's physical needs.

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

Sources: resident clinical record review of progress notes, PT Assessment, and care plan; and interviews with the resident and the DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 resident's plan of care was provided related to the administration of medication.

A review of the resident's care plan indicated the resident's specific directions for medications administration and the Director of Care (DOC) advised that staff were not following the resident's care plan concerning medication administration.

Sources: complaint intake, review of resident electronic records, review of the home's policy "24-hour care plan and plan of care", an interview with the complainant and the DOC.

WRITTEN NOTIFICATION: Skin & Wound

NC #004 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

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

injuries, skin tears or wounds,

(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident was reassessed at least weekly for altered skin integrity.

A complaint was reported to the Ministry of Long-Term Care related to an altered skin integrity caused during care.

Skin & Wound Evaluations documented an initial assessment and a resolved assessment with two assessments missed.

Sources: resident clinical record review of progress notes, Skin & Wound Evaluations, and the Treatment Records and hospital records; and interviews with the resident, nursing staff and the DOC.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident had an individualized plan to promote and manage bladder and bowel continence based on their continence

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

assessment and that the plan was implemented.

The plan of care failed to specify the frequency of changes for incontinence products and a toileting schedule, as recommended by the continence assessment completed upon admission to the home.

Sources: Review of resident's plan of care and continence assessment, and interviews with the DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that the verbal complaint made by a resident that alleged physical harm was immediately investigated and resolved where possible.

A complaint was reported to the Ministry of Long-Term Care (MLTC) that a resident accused the home of harm during care.

DOC stated they were unaware of the resident's reported complaint and verified

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

although there was clinical follow up, there was no immediate investigation related to the reported injury during care. There was no investigation by the registered staff or the DOC, no interviews with Personal Support Workers who were present during care and a Client Service Response Form was not completed as required.

Sources: MLTC Complaint Intake, resident clinical record review of progress notes, TRC Comprehensive Pain Assessment, and hospital records; Management Reporting of Complaints Policy, observations of the resident and interviews with the resident, nursing staff and the DOC.

WRITTEN NOTIFICATION: Reports Critical Incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee failed to ensure that the Director was immediately informed of the unexpected and sudden death of a resident.

The resident passed away unexpectedly and there was a physician progress note and a Death Summary that identified the death as unexpected. There was no mandatory Critical Incident report submitted to the MLTC.

Sources: clinical record review of the resident and interview with the Director of

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

Care and Executive Director.

WRITTEN NOTIFICATION: Medication

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (3)

Administration of drugs

s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,

(a) where the administration involves the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is authorized to administer the drug by virtue of a health profession Act, the Regulated Health Professions Act, 1991 or any relevant regulation; or

(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,

(i) a member of a regulated health profession and is acting within their scope of practice,

(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,

(A) meets the requirements set out in subsection 52 (1) or who is described in subsection 52 (2), or

(B) is an internationally trained nurse who is working as a personal support worker.

O. Reg. 66/23, s. 28 (1). Or

(iii) a nursing student extern who has received training in the administration of drugs

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

in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home and who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario.

The licensee has failed to ensure that no person administers a controlled and non controlled drug to a resident according to the legislation.

A complaint was received by the Director concerning Personal Support Workers (PSWs) administering medications to a resident.

A Memo from the DOC to the home's staff dated stated "It has come to my attention that some registered staff are asking PSWs to take medication that they have prepared and give to the residents. This is not an acceptable practice".

The DOC said registered staff were not monitoring that the resident was taking their medication.

Sources: complaint intake, review of resident's electronic records, review of the home's policy "The Medication Pass", review of a "Memo" from the DOC, an interview with the complainant and the DOC.

WRITTEN NOTIFICATION: Medication

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 146 (a)

Residents' drug regimes

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

s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee failed to ensure that a resident who was taking a drug was monitored, there was documentation of the resident's response to the medication, and the effectiveness of the drug.

The resident had an infection and was prescribed a medication. There was no documentation the resident was monitored for six shifts during the course of the medication. There was no documentation of the resident's symptoms related to their infection and no documented record of the effectiveness of the medication through clinical observation. The resident's symptoms could have declined potentially causing an adverse health outcome.

Sources: complaint intake, review of resident's electronic records, and an interview with the complainant and the DOC.

COMPLIANCE ORDER CO #001 Care Conference

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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;

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

**The inspector is ordering the licensee to comply with a Compliance Order
[FLTCA, 2021, s. 155 (1) (a)]:**

Specifically, the licensee must:

1. Ensure that a care conference with the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission for all residents admitted to the home after May 1, 2025.
2. Ensure all outstanding six week admission care conferences have been completed by the compliance order due date, at a minimum, including those admitted since January 2025.
3. Ensure the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences.
4. A record is kept of the date, the participants, and the results of the conferences as part of the resident's PointClickCare electronic health record.
5. Develop, document, and implement a process to ensure residents admitted to the home receive a care conference with the interdisciplinary team within six weeks of admission to the home.

Grounds

The licensee has failed to ensure that a care conference with the interdisciplinary team providing resident care was within six weeks following admission of seven residents to discuss plan the plan of care and other matters of importance to resident and their substitute decision maker (SDM), if any.

The DOC and Resident Care Coordinator acknowledged that the home was behind on their care conferences. They confirmed all admissions for February 2025 had not had their six-week admission conferences completed. The DOC reported that the home admitted seven residents during February 2025.

A record review showed none of the six-week care conferences for these seven

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

admissions had been completed.

Sources: Interviews with the DOC and Resident Care Coordinator, and review of Admission Interdisciplinary Care Conferences.

This order must be complied with by June 16, 2025

COMPLIANCE ORDER CO #002 Dealing with Complaints

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 108 (2)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

- (a) the nature of each verbal or written complaint;
- (b) the date the complaint was received;
- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- (d) the final resolution, if any;
- (e) every date on which any response was provided to the complainant and a description of the response; and
- (f) any response made in turn by the complainant.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with O. Reg. 246/22, s. 108 (2).

Specifically, the licensee must:

- a) Ensure that every verbal complaint made by two identified residents to the licensee or a staff member of the home concerning their care is dealt with according to the home's written procedures for initiating complaints.

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

b) Ensure that a documented record of any complaints identified in a) are kept in the home for both residents that includes everything identified as part of Ontario Regulation 246/22, s. 108 (2).

c) Ensure the Director of Care and all Registered Nursing Staff receive training on the written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

Grounds

The licensee failed to ensure that a documented record of the verbal complaint by two residents was kept in the home and included all the required information.

Two separate complaints were reported to the Ministry of Long-Term Care (MLTC) concerning the care of two residents.

The Management & Reporting of Complaints Policy documented, Registered Staff will initiate the "Client Service Response Form" and begin investigation of complaint/concern, and if the complaint remains unresolved, complete the Client Service Response (CSR) Form and forward it to the appropriate Department Manager for further follow-up. The Director of Care (DOC) verified a Client Service Response Form was not completed as required.

Sources: MLTC Complaint Intake, residents clinical record review; Management Reporting of Complaints Policy, observations of the residents and interviews with the residents, the complainant, nursing staff and the DOC.

This order must be complied with by June 16, 2025

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

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

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

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

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

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.