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: October 23, 2023
Inspection Number: 2023-1225-0004
Inspection Type: Critical Incident
Licensee: Sharon Farms & Enterprises Limited
Long Term Care Home and City: Kensington Village, London

Lead Inspector	**Inspector Digital Signature**
Christie Birch (740898)	Christie Birch Digitally signed by Christie Birch Date: 2023.10.26 14:31:38 -04'00'

Additional Inspector(s)
Tatiana Pyper (733564)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12, 13, 16, 18, 2023
The inspection occurred offsite on the following date(s): October 17, 2023

The following intake(s) were inspected:

- Intake: #00093631 - CI - 2729-000013-23: Fall of resident resulting in injury.
- Intake: #00094915 - CI -2729-000022-23: Fall of resident resulting in injury.
- Intake: #00096763 - CI -2729-000026-23: Resident to resident abuse.
- Intake: #00096765 - CI -2729-000027-23: Outbreak.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee to Stay in Contact

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 153

The licensee failed to ensure that they maintained contact with a resident, or with the resident's health care provider, who was on a psychiatric absence in order to determine when the resident would be returning to the home.

Rationale and Summary

A Critical Incident (CI) was sent to the Director related to allegation of abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

A review of the resident's progress notes indicated initial contacts in the first week after resident admitted to hospital, with the resident's healthcare provider but no further documentation of communication with the hospital or the resident thereafter.

A review of the Leave of Absence- Release of Responsibility Policy noted the following:
" 6. (2)The RN/RPN will process a medical leave (30 days) as follows:
-The RN/RPN will contact the hospital on a regular basis (every 48 hours) to obtain an update on the Resident's health status, including their anticipated date of return. The interaction will be documented on the NPN[nursing progress notes].
7. The RN/RPN will process a psychiatric leave (60 days) as outlined above."

During interviews with the Assistant Director of Care /Behavioural Support Lead, and the Director of Care, they acknowledged that they were aware there had been no further communication with the healthcare providers at the hospital and that they would have expected the home to stay in contact while the resident was on leave in the hospital.

The lack of contact between the resident or healthcare provider and the home is a risk to this resident related to possible delayed discharge planning.

Sources: Record review of progress notes in Point Click Care, CI, Policy, Leave of Absence- Release of Responsibility Policy Effective Date - September 1, 2017, revised date- August 13, 2021 ; Interviews with staff.

[740898]