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: January 29, 2024
Inspection Number: 2024-1225-0001
Inspection Type: Critical Incident
Licensee: Sharon Farms & Enterprises Limited
Long Term Care Home and City: Kensington Village, London

Lead Inspector	**Inspector Digital Signature**
Ina Reynolds (524)	Ina Reynolds Digitally signed by Ina Reynolds Date: 2024.01.29 13:49:21 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23 and 25, 2024.

The following intake(s) were inspected:

- Intake: #00103421 CIS #2729-000036-23 related to Falls Prevention and Management

The following intake(s) were completed in this inspection:

- Intake: #00097286 CIS #2729-000028-23 related to Falls Prevention and Management
- Intake: #00101257 CIS #2729-000032-23 related to Falls Prevention and Management
- Intake: #00103458 CIS #2729-000037-23 related to Falls Prevention and Management.

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

Infection Prevention and Control
Falls Prevention and Management

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.

The licensee has failed to ensure that the plan of care for a resident related to the use of an assistive device was revised when the resident's care needs changed.

Rational and Summary:
A resident had an unwitnessed fall resulting in an injury and required medical treatment.

On two occasions, Inspector observed the resident using an assistive device while being seated. This was confirmed by a staff member. The staff member said that the

resident required the assistive device as the resident was at risk for falls. The staff member said they would look at the Kardex on Point of Care for resident care interventions.

Review of the resident's plan of care and Kardex on PointClickCare (PCC) showed there was no directions for staff to the use of the assistive device as a fall intervention.

The Director of Care (DOC) after review acknowledged the plan of care was not revised to include the assistive device and the care plan was then updated. There was low risk to the resident at the time of the observation.

Sources: Observations of a resident, the resident's clinical records, and interviews with the DOC and other staff.
[524]

Date Remedy Implemented: January 25, 2024