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

Original Public Report

Report Issue Date: May 18, 2023

Inspection Number: 2023-1475-0004

Inspection Type:
Follow up
Critical Incident System

Licensee: Sharon Farms & Enterprises Limited

Long Term Care Home and City: Earls Court Village, London

Lead Inspector	**Inspector Digital Signature**
Debbie Warpula (577)	Debbie L Warpula Digitally signed by Debbie L Warpula Date: 2023.05.19 09:13:47 -04'00'

Additional Inspector(s)
Meagan McGregor (721)
Rhonda Kukoly (213)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9, 10, 11 and 15, 2023

The following intake(s) were inspected:

- Intake: #00021534 – related to a missing resident
- Intake: #00083923 – related to a fall of a resident with injury
- Intake: #00084099 - Follow-up # 1 – Compliance Order #001 from Inspection #2023-1475-0003 related to FLTCA, 2021 - s. 24 (1)
- Intake: #00084100 - Follow-up # 1 – Compliance Order #002 from Inspection #2023-1475-0003 related to O. Reg. 246/22 - s. 123 (3) (a)
- Intake: #00085612 – related to alleged neglect of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1475-0003 related to FLTCA, 2021, s. 24 (1) inspected by Debbie Warpula (577)

Order #002 from Inspection #2023-1475-0003 related to O. Reg. 246/22, s. 123 (3) (a) inspected by Debbie Warpula (577)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that monitoring of a resident for changes in their condition and care needs was provided to the resident as specified in their plan of care.

During an evening shift, a staff member input the code to the main entrance doors for a resident allowing them to exit the home and did not inform any staff members of their departure. The following morning, the PSW's assigned to the resident's care on day shift came to check on the resident in their room and identified that they were missing from the home. A code yellow emergency plan was called and search for the resident was initiated at this time. The resident returned to the home on their own without any change in their condition.

In accordance with the home's policy related to nighttime safety of residents, PSW's were expected to

complete visual resident safety rounds at the start and end of their shift and routine bed checks at a minimum twice during the night and according to individualized needs.

The resident's care plan indicated they required specific monitoring for their medical condition.

The Executive Director (ED) indicated that staff were expected to complete monitoring and safety checks for all residents at a frequency individualized to the resident and indicated in their plan of care, including those who were independent, unless otherwise indicated in the residents plan of care that they do not wish to be disturbed. They said they expected that the PSW staff who were working on that evening and night shift should have monitored the resident as specified in their plan of care.

As a result of staff not completing monitoring as specified in the resident's plan of care, staff did not identify that the resident was missing from the home and activate their code yellow emergency plan to locate and ensure the residents safety until approximately 13 hours after the resident left the home.

Sources: a CIS report, a resident's clinical record, the home's policy; the home's investigation notes, and interviews with staff.
[721]

WRITTEN NOTIFICATION: Falls Prevention

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that when a resident fell, specific monitoring was initiated prior to transfer to a medical facility.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure the home's falls prevention and management program was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's Head Injury Routine policy and Fall Management policy which was part of the licensee's Falls Prevention and Management Program.

Rationale and Summary:

A Critical Incident (CIS) System report was submitted to the Director concerning a resident who had an unwitnessed fall and required medical care.

Review of the home's policy "Falls Prevention and Management" indicated that if a fall was not witnessed or the resident had hit their head, the Head Injury Routine (HIR) would be initiated.

Review of the home's policy "Head Injury Routine" indicated that an HIR would be initiated for all falls that were not witnessed, and for witnessed falls that include the possibility of a head injury.

During a record review of the resident's records, Inspector #577 noted that the specific monitoring record was not initiated.

During an interview with the Acting DOC, they confirmed that staff did not initiate or complete the specific monitoring records as required.

The home not initiating and completing the resident's specific monitoring put the resident at risk as they failed to assess their particular status as required.

Sources: review of a CIS report, review of the resident's medical records, review of the home's policies, and interviews with staff.

[577]