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
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Original Public Report

Report Issue Date: September 22, 2023	
Inspection Number: 2023-1475-0006	
Inspection Type: Critical Incident	
Licensee: Sharon Farms & Enterprises Limited	
Long Term Care Home and City: Earls Court Village, London	
Lead Inspector Stephany Kulis (000766)	**Inspector Digital Signature** Stephany Kulis Digitally signed by Stephany Kulis Date: 2023.09.26 13:25:16 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 8, 11, 13, 14, 2023
Present on inspection: Carol Polcz (156)

The following intake(s) were inspected:

- Intake: #00094820 - IL-16517-AH/3047-000022-23: Fall of a resident resulting in an injury.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure a resident's plan of care had clear direction for staff on locomotion with assistive device.

Rationale and Summary
A resident's plan of care was not clear when their family brought in an assistive device to use as per Physiotherapist (PT) recommendations. As per PT notes, a resident was to start using an assistive device for safe functional mobility earlier this year. However, the care plan was not updated after it was brought in. This was revised after the resident fell and was no longer using their assistive device due to change in status. There were unclear directions for staff as to what a resident should be using for locomotion up until a resident fell. Director of Care (DOC) stated a resident had been using their assistive device since the assessment until the time of the fall and physiotherapy did not update the directions in the care plan.

As a result, a resident's plan of care did not provide clear direction of locomotion with an assistive device and there was a risk for resident not receiving the care required.

Sources
Interview with DOC; PT progress notes; Resident's plan of care
[000766]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure a resident was re-assessed by physiotherapy when the resident's care needs changed after a fall.

Rationale and Summary
Staff failed to complete a physiotherapy re-assessment of a resident after they had a fall. A resident's plan of care indicated use of mechanical lift until physio re-assessment. Physiotherapy referral for a resident sent on the same day as their fall. PT stated they have received the referral to re-assess a resident but have not completed the re-assessment. DOC stated this does not comply with the home's expectation for re-assessments to be completed when a resident has a change in status.

As a result, a resident was not re-assessed when there was a change in status and there was no current direction for staff on transferring and positioning resident putting the resident at risk for functional

decline.

Sources
Interview with DOC and PT; Post-fall assessment; Resident's care plan
[000766]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (3)

The licensee failed to ensure a resident's plan of care covered restorative care.

Rationale and Summary
Restorative care is used to help resident's maintain and restore their optimal level of functioning. DOC indicated a resident was once part of the home's restorative program which included physiotherapy but due to refusals they were discontinued from the program. DOC stated the plan of care components included restorative, nursing, dietary and recreation but there was no documentation in the plan of care that a resident was part of the restorative program. According to a resident's plan of care, there were no restorative care components.

As a result, the resident was at risk of losing their functional ability if restorative care is not implemented in their care.

Sources
Resident's care plan, Interview with DOC
[000766]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

A. The licensee failed to ensure a resident's fall interventions were in place at the time of inspection.

Rationale and Summary
In a resident's plan of care, the documented fall interventions included specific directions for staff

related to call bell and a device to decrease injury. During an observation of a resident in their chair, it was noted specific directions for staff related to the call bell were not being followed as per the resident's plan of care. Personal Support Worker (PSW) was in the room and confirmed this. PSW checked if the resident was wearing a device to decrease injury as per the inspector's request and the resident was not wearing them either.

As a result, a resident did not have their identified fall interventions in place.

Sources
Interview with PSW; Resident observation; Resident's care plan
[000766]

B. The licensee failed to ensure a resident's fall interventions were in place when they fell.

Rationale and Summary
In a resident's plan of care, the documented fall interventions included specific directions for staff related to call bell and a device to decrease injury. A resident had an unwitnessed fall in the evening resulting in transfer to hospital and multiple injuries. PSW discovered a resident on the floor when they fell and stated staff were not following specific directions related to the call bell as per the resident's plan of care. DOC stated the device to decrease injury were also not on the resident at the time of the fall.

As a result, a resident did not have their identified fall interventions in place at the time of the fall.

Sources
Interviews with DOC and PSW; Resident care plan; CI report
[000766]

WRITTEN NOTIFICATION: Binding on licensees

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every requirement of the Minister’s Directive: COVID-19 response measures for long-term care homes that applies to the long-term care home.

In accordance with section 7 of Minister's Directive: COVID-19 response measures for long-term care homes, the Licensee was required to ensure that the requirements for visitors during outbreaks as set out in the document are followed.

Rationale and Summary

In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes, effective August 30, 2022, and Ministry of Health: COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings effective June 26, 2023; visitors are required to comply with masking/personal protective equipment (PPE) requirements as appropriate during outbreaks

An unmasked visitor was observed with a resident during lunch time in the dining room. The home's Infection Prevention and Control (IPAC) lead #102 said visitors are required to mask during an outbreak as per public health direction and the home's visitor policy. In accordance with the home's visitor policy, when there is an outbreak visitors must comply with masking and PPE requirements.

As a result, there was potential for the spread of infectious disease when an unmasked visitor was within 2 meters of multiple residents on an outbreak unit.

Sources
Interview with IPAC lead #102; Minister's Directive: COVID -19 response measures for long-term care homes; Ministry of Health: COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings; Observations.
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