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: December 7, 2023

Inspection Number: 2023-1475-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Sharon Farms & Enterprises Limited

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

Lead Inspector	**Inspector Digital Signature**
Samantha Perry (740)	Samantha Perry Digitally signed by Samantha Perry Date: 2023.12.07 11:13:35 -05'00'

Additional Inspector(s)
Ali Nasser (523)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 29, 2023 and December 1, 4, 5, 2023
The inspection occurred offsite on the following date(s): November 30, 2023

The following intake(s) were inspected:
Intake: #00095486 - Complaint related to falls prevention and management, and personal support services;
Intake: #00096692 - CI #3047-000024-23 related to a COVID-19 outbreak;
Intake: #00096978 - CI #3047-000025-23, related to resident to resident physical abuse;
Intake: #00098395 - Complaint related to nursing and personal support services;
Intake: #00101936 - CI #3047-000030-23, related to alleged resident neglect;

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Intake: #00102047 - Complaint related to pain and skin and wound care management.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Pain 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 (2)
Plan of care
Based on assessment of resident
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 has failed to ensure that a resident's plan of care was based on their skin and wound care needs and assessments.

Rationale and summary:

The Ministry of Long Term Care (MLTC) received a complaint related to the wound care management of a resident.

A clinical record review for the resident documented they had multiple areas of altered skin integrity. The areas were being assessed and re-assessed by a health care provider, and the provider had suggested a change to the resident's treatment plan, which was not implemented right away. This impacted the resident's right to timely wound care management and increased the resident's risk of stalled wound healing.

Personal support workers (PSW), registered nursing staff, and further review of the resident's clinical records supported the resident's areas of altered skin integrity were not improving until the prior treatment plan suggested was implemented.

Director of Care (DOC), said they were unsure why the treatment plan was not implemented right away, and the resident's areas of altered skin integrity have improved since the new treatment plan was started.

Sources: Resident clinical record review, interviews with staff and management. [740]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments,

reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the needs of a resident, including assessments and interventions when a resident was demonstrating responsive behaviours.

Rational and Summary:
The home submitted a Critical Incident System (CIS) report related to allegations of resident to resident physical abuse.

In an interview Director of Care (DOC) said a resident had a newly expressed responsive behaviour involving another resident. The DOC said the expectation of staff were for them to complete a responsive behaviour assessment at the time of the new or worsening behaviour.

The DOC reviewed the resident's clinical records and said there were not able to find an assessment related to the resident's newly expressed responsive behaviours and this put the resident and their co-residents at risk.

Sources: record reviews and staff interviews. [523]