Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 30, 2019	2019_727695_0021	005349-19, 006895-19	Critical Incident System

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

Long-Term Care Home/Foyer de soins de longue durée

Strathcona Long Term Care
720 Princess Street MOUNT FOREST ON N0G 2L3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

FARAH_ KHAN (695)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 18, 19, 23, 24, and 25, 2019.

During the course of the inspection, the following Critical Incident intakes were inspected:
Intake #005349-19, related to a fall during transfer and
Intake #006895-19, related to a fall that resulted in injury.

The inspector(s) also toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, and policies and procedures.

During the course of the inspection, the inspector(s) spoke with family members, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), the Nurse Manager, the two co-Director of Cares (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a 24-hour admission care plan was developed for resident #006.

According to resident #006's clinical record, they were admitted to the home on a specific date in 2019. The resident had two previous admissions to the home.

A review of resident #006's paper chart found a 24-hour admission care plan signed by a registered staff member from the first time they were admitted to the home. There were no other 24-hour admission care plans found and the resident's electronic care plan for the most recent admission had not been completed.

DOC #109 stated that they do not create new 24-hour admission care plans when a resident is re-admitted to the home but will update the old one if there were any changes. They acknowledged that a 24-hour admission care plan was not completed for the resident's most recent admission, and that the one from their first admission had no indication that it was reviewed or updated.

The licensee failed to ensure that a 24-hour admission care plan was developed for resident #006. [s. 24. (1)]

2. The licensee failed to ensure that a 24-hour admission care plan was developed for resident #003 that included the resident's transfer status.

A Critical Incident was submitted to the Ministry of Long-Term Care (MLTC) which stated

that on a specific date at a specific time, resident #003 fell during a transfer with PSW #110 and sustained an injury. The resident was sent to hospital where they were monitored for a condition.

The incident occurred within a week of the resident's admission to the home and a record review found that the 24-hour admission care plan was initiated but not completed and that specifically, the transfer status was not identified.

In an interview with the DOC, they acknowledged that the 24-hour admission care plan and transfer assessment were required to be completed within 24 hours of admission and were not completed for resident #003.

The licensee failed to ensure that a 24-hour admission care plan was developed for resident #003 that included the residents transfer status when the resident was first admitted to the home. [s. 24. (2) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the 24-hour admission care plan is developed for every new admission, to be implemented voluntarily.

Issued on this 8th day of August, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.