Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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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
Apr 16, 2019	2019_755728_0006	015198-17, 027351-17, 001428-18, 006834-18, 007763-18, 007821-18, 009387-18, 011766-18, 015630-18, 015982-18, 016743-18, 018139-18, 018817-18, 022703-18, 024440-18, 003082-19	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

MARIA MCGILL (728), KIM BYBERG (729), KRISTAL PITTER (735), SHERRI COOK (633)

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): March 4-8, 11-15, and 19-21, 2019

The following intakes were completed as part of this critical incident inspection:
Log #027351-17, Log #006834-18, Log #001428-18, Log #022703-18, Log #009387-18, related to falls;
Log #016743-18, Log #018817-18, related to alleged staff to resident physical abuse;
Log #007821-18 , Log #015198-17, related to alleged resident to resident sexual abuse;
Log #015630-18, related to alleged resident to resident verbal abuse;
Log #015982-18, Log #011766-18, Log #007763-18, related to resident to resident altercations/responsive behaviours;
Log# 003082-19, related to a complaint regarding short staffing, dining and snack services, and doors in the home;
Log #024440-18, Log #018139-18, related to medication administration and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Acting Director of Care (Acting DOC), the Assistant Director of Care/ BSO Lead (ADOC), the Director of Dietary Services, the Activity Manager, the Nurse Clerk, the Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity Aides, Physiotherapy Assistants (PTA), Dietary Aides, Housekeeping, residents, and family members.

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, staffing schedules, relevant home documentation and investigations, relevant meeting minutes, and interviewed residents and staff.

Observations were made of infection prevention and control practices, provision of care, staff to resident and resident to resident interactions, dining and snack services, staffing, relevant equipment in resident's rooms and in the home, and medication administration, and medication storage areas.

This inspection was completed concurrently with post-occupancy inspection 2019_755728_0005. During the post-occupancy inspection, observations were completed of doors in the home and dining services.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A) The home's policy "Zero Tolerance of Abuse and Neglect HR-J-15" last revised December 21, 2017, stated that the investigation would include the RN initiating the "Abuse Checklist for Investigating Alleged Abuse" and they would also obtain written statements from all witnesses. The DOC, Administrator, or designate would assume the investigation lead which included obtaining written statements from all concerned parties and the resident, if able. They would also continue the checklist for reporting and investigating alleged abuse.

The "Abuse Checklist for Investigating Alleged Abuse" last revised December 2017, stated that this checklist was to be used for any suspected or actual abuse of a resident. The checklist included actions to be completed as well as indicating the person responsible, date, and signature.

The home's policy "Resident Non-Abuse LP-C-25" last revised February, 2018, stated that the Administrator would maintain confidential files that would include any statements, interviews, meeting minutes, and any other documentation generated by the investigation.

DOC #104 stated that nursing checklists were part of their policy. However, they were not written on or maintained as part of the investigation records. They said that the RN documented verbal statements in risk management; however, sometimes written statements were completed and other times not. The DOC said that management does not obtain written statements from all staff and/or the residents involved.

i) A critical incident (CI) was submitted to the Ministry of Health and Long-term Care (MOHLTC) related to an incident of alleged staff to resident abuse. The CI indicated that PSW #116 reported an incident of alleged verbal abuse to management.

The home's documentation included an untitled document that was dated the day after the alleged incident, which detailed their discussions with PSW #116 and PSW #129. The home's documentation did not contain an "Abuse Checklist for Investigating Alleged Abuse" and did not contain any written statements from witnesses.

PSW #116 said that they did not complete a written statement or discuss the incident with management after they had verbally reported their concern [728].

ii) Two CIs were submitted to the MOHLTC both related to alleged abuse. The home's investigation records did not include an abuse checklist and there were no written statements from those involved.

PSW #137 stated they were not asked and they did not complete a written statement. They also said that they were not interviewed by management related to the incident.

RN #118 and #138 both stated that they were unaware of an abuse checklist. RN #138 said that they were to document information reported to them in the risk management section of PointClickCare (PCC). They did not investigate further and they did not interview the resident or obtain written statements from all involved. [633].

iii) A CI was submitted to the MOHLTC related to alleged staff to resident abuse.

A review of the home's investigation records did not include written statements from any of the three witnesses nor did it include the abuse checklist for investigating alleged abuse.

PSW #137, Physiotherapy Assistant (PTA) #111 and Housekeeper #126 were questioned by the management team related to the incident. There were no written statements in the home's investigation file.

Acting DOC #103 shared that they took a few notes during the investigation but did not take statements from those staff and residents involved [729].

iv) A CI report was submitted to the MOHLTC related to staff to resident abuse and neglect. The CI documented that on a specified date, resident #016 reported an allegation of improper care/neglect.

RPN #122 said that they interviewed resident #016, completed the risk management report in PCC, and notified the RN of the concern. They did not complete an abuse checklist for investigating alleged abuse and shared that they were not aware of the checklist [729].

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with related to completing and documenting alleged abuse investigations.

B) The home's policy titled "Zero Tolerance of Abuse and Neglect" last revised December 21, 2017, directed all staff members that they were obligated to immediately report any incidents or suspected incidents of resident abuse.

i) A critical incident (CI) was submitted to the MOHLTC, related to an incident of alleged staff to resident abuse. The CI indicated that PSW #116 reported an incident of alleged verbal abuse to management.

The home's documentation related to the incident stated that PSW #116 did not immediately report the incident of alleged verbal abuse that they had witnessed.

PSW #116 said that the expectation was to report any incidents of alleged, suspected, or witnessed abuse immediately and that with this incident they did not. DOC #104 said that the expectation is that staff report incidents of alleged abuse immediately [728].

ii) A CI was submitted to the MOHLTC, related to alleged staff to resident abuse.

A review of the CI indicated that the incident occurred on a specified date. The CI documented that Administrator #102 was made aware of the incident fourteen days later.

Housekeeper #126 said that they reported the incident to the Acting DOC #103 four days later when they returned to work. Housekeeper #126 said that they should have reported it immediately after the incident occurred.

PSW #137 said Administrator #102 followed up with them regarding the incident twelve days after the incident occurred.

The Acting DOC did not know the exact date that they were notified of the incident. There were inconsistencies with the dates that the alleged incident was reported to management and there was no documentation in the investigation that identified when management became aware of the incident. DOC #104 said that staff were expected to report their allegations of witnessed or suspected abuse to the home immediately [729].

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with related to staff immediately reporting incidents of alleged abuse. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

The licensee has failed to shall ensure that all staff at the home have received training as required by this section.

Critical incidents related to alleged abuse were submitted to the MOHLTC.

A) LTCHA 2007, c. 8, s. 76 (2) states that the licensee shall ensure that prior to any person performing responsibilities in the home, the licensee is responsible to ensure that training is provided related to the following: the residents bill of rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; fire prevention and safety; emergency and evacuation procedures; infection prevention and control; acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities; and, any other areas provided for in the regulations

Agency staff member #128 and #138 said that upon hire they completed on-site orientation to the home. DOC #104 was unable to provide the orientation training records for Agency staff members #128, #138 and #139. The DOC said that the Agency had been contracted and were responsible to ensure that mandatory training was provided to their employees.

Agency Manager #134 said the A Supreme Nursing and Homecare Orientation Manual

was the training material provided to staff working in long-term care. The orientation manual did not include the home specific policies and procedures. Staff were to review the material and sign off on completion upon hire and annually thereafter. In-services were provided for updated material only.

The Agency was unable to provide their orientation records for staff members #138 and #139.

B) LTCHA, 2007, c. 8, s. 76 (7) states that every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations including: abuse recognition and prevention; mental health issues, including caring for persons with dementia; behaviour management; how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations; palliative care; any other areas provided for in the regulations.

O Reg. 221. (1)(2)(3)(4) stated that staff must receive annual training in all these areas and identified the additional training requirements for all staff.

The DOC was unable to provide any annual training records for the agency staff members that had worked in the home. The DOC said the Agency was responsible to provide the annual training on the homes specific policies and procedures for their Agency staff.

Agency staff member #128 said they had not received annual training from the Agency. Agency staff member #138 said they had completed the annual training; however, they could not identify when and if this training had included the home's specific policies and procedures. The "A Supreme Nursing and Homecare Orientation Manual", dated 2018-2019, did not include any of the home's specific training material.

From March 14 to 19, 2019, the DOC said that they requested the training records for the three identified agency staff members and two additional agency staff. The Agency did not provide any annual training records to the home.

Staff abuse training records for Agency registered staff members #128, #138 and #139 were requested from the DOC. DOC #104 said that the home had contracted A-Supreme Nursing and Homecare for their Agency staff and the Agency was responsible to provide

the training as set forth in the Act and regulations. The DOC said this included the home's specific policies and procedures.

The home's abuse policy "Zero Tolerance of Abuse and Neglect", last revised December 21, 2017, stated that all staff would receive in-service education on abuse and neglect upon hire and annually thereafter.

The home's policy "Resident Non-Abuse" last revised February, 2018, stated that all persons that interacted with residents on a regular basis would complete abuse intervention training (S.T.O.P program) prior to commencing work and annually thereafter. Sign off forms would be retained in the employee file.

The home was unable to provide any additional training records in relation to the Agency staff. The DOC said that they did not maintain files for Agency staff but were aware that it was their responsibility to ensure that the training was completed.

The licensee has failed to ensure that all agency staff at the home received training as required before agency staff worked at the home and annually thereafter as set forth in the Act and regulations. [s. 76. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every resident was treated with courtesy and respect in a way that fully recognized the resident's individuality and respected their dignity.

A) A critical incident (CI) report was received by the MOHLTC related to alleged staff to resident verbal abuse. The CI documented a verbal interaction between PSW #129 and resident #017 that staff reported to be inappropriate.

PSW #116 who witnessed the incident stated that the resident would not have understood the comment but that they felt it was not respectful to the resident.

The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognized the residents' individuality and respected the residents' dignity [728].

B) A CI was submitted to the MOHLTC, alleging an incident between PSW #130 and resident #006 that staff said was inappropriate.

PSW #137, Physiotherapy Assistant (PTA) #111, Housekeeper #126, shared that they witnessed the incident. They said that the staff members interaction with the resident was not appropriate.

Acting DOC #103 shared that the resident's bill of rights meant that residents would have a choice, they would have their wishes followed, and the home was to keep residents safe especially those who could not speak for themselves. They said that resident #006 was not able to verbally respond but that they were able to follow direction.

The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognized the residents' individuality and respected the residents' dignity [729]. [s. 3. (1) 1.]

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 residents were treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

A) The licensee has failed to protect resident #011, #014, #015 from abuse by anyone.

The definition of sexual abuse in subsection 2 (1) of the Regulation, states "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

i) A critical incident report (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to the alleged sexual abuse by resident #012 towards resident #011 on an identified date. The CI stated that PSW #120 observed resident #012 exhibiting sexually inappropriate behaviour towards resident #011.

Resident #011 was not interviewable. Their plan of care stated that they had severe cognitive impairment and required assistance by staff for care.

The home's incident report in risk management stated that resident #012 was sexually inappropriate with another resident. PSW #135 stated that resident #012's actions were sexual abuse. Resident #011 did not sustain a physical injury and the home took appropriate actions in response to this incident.

ii) A CI report was submitted to the MOHLTC related to the alleged sexual abuse by resident #013 towards resident's #014 and #015. Resident #013 was observed exhibiting sexually inappropriate behaviour towards resident #014. Resident #013 left the area and was then observed exhibiting sexually inappropriate behaviour towards another resident.

Resident #014 and #015 were not interviewable.

The licensee has failed to protect resident #011, #014 and #015 from sexual abuse.

B) The licensee has failed to protect resident #006 from abuse by anyone.

Physical abuse is defined in subsection 2 (1) of the Regulation, to include "the use of physical force by a resident that causes physical injury to another resident".

i) A number of CIs were submitted to the MOHLTC related to resident to resident altercations between resident #006 and resident #007 over a six month period. The CIs documented that each altercation resulted in injuries to resident #006.

The plan of care stated that resident #006 exhibited a specified behaviour. Resident #007's plan of care documented responsive behaviours.

ADOC/BSO Lead #121 said that because of the nature of the residents' responsive behaviours, they would trigger each other.

The licensee failed to protect resident #006 from abuse by resident #007. (728) [s. 19. (1)]

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident's responses to interventions were documented.

Resident #008 sustained a fall on an identified date, that resulted in an injury. The resident's fall was documented to be unwitnessed. The head injury routine (HIR) was initiated after the resident fell and documented in PointClickCare (PCC) assessments. The head injury routine was documented in PCC on three occasions.

A review of the resident's plan of care identified a form titled "Saugeen Valley Nursing Center Head Injury Routine" that directed staff to complete the HIR in PCC every 15 minutes for one hour, followed by every 30 minutes for two hours, then every hour for four hours, and then every eight hours up to 72 hours. The form identified that the registered staff member signed that this assessment had been completed but did not document the details of the assessment or the resident's responses.

RN #123 and DOC #104 said that the HIR was to be documented in the assessments tab of PCC. DOC #104 said that the HIR was initialed to have been completed by the registered staff member but that the details of the findings of the HIR assessment were not documented in the resident's plan of care for ten of the assessments that were initialed to have been completed.

The licensee has failed to ensure that the findings of the HIR assessment that was initialed to have been completed in resident #008's plan of care were documented following an unwitnessed fall on March 19, 2018. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A CI report was submitted to the MOHLTC, that documented resident #004 was to have had a specified medication administered. RPN #113 identified that it may not have been administered.

No Medication Incident Report was completed for the medication incident.

RPN #113, RPN #124, and DOC #103 stated that Medication Incident Reports were completed by registered staff after a medication incident occurs. They said that the Medication Incident Report for this incident had not been completed.

The licensee failed to document a medication incident, involving resident #004, together with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

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 every medication incident involving a resident documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the results of every abuse investigation was reported to the Director.

A CI was submitted to the MOHLTC, alleging an incident of alleged abuse.

The CI report was amended on an identified date but it did not include the results of the alleged abuse investigation.

Acting DOC #103 shared that they were unaware of the reason why the CI report was not amended with the results of the investigation.

The licensee has failed to ensure that the results of every abuse investigation were reported to the Director. [s. 23. (2)]

Issued on this 16th day of May, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA MCGILL (728), KIM BYBERG (729), KRISTAL PITTER (735), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2019_755728_0006
Log No. / No de registre :	015198-17, 027351-17, 001428-18, 006834-18, 007763-18, 007821-18, 009387-18, 011766-18, 015630-18, 015982-18, 016743-18, 018139-18, 018817-18, 022703-18, 024440-18, 003082-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 16, 2019
Licensee / Titulaire de permis :	Sharon Farms & Enterprises Limited 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home / Foyer de SLD :	Strathcona Long Term Care 720 Princess Street, MOUNT FOREST, ON, N0G-2L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cate MacLean

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Sharon Farms & Enterprises Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s.20(1) of the LTCHA, 2007.

Specifically, the licensee must:
a) Ensure that investigations are completed for each incident of alleged, suspected, or witnessed abuse or neglect and that the investigations include written statements from all possible witnesses;
b) Ensure that registered staff #137, #118, #138, #122, and any other staff are trained on the process for completing investigations as per the home's policy;
c) Ensure that all documentation related to the investigation is maintained together in a secure location accessible by the Administrator; and,
d) Ensure that staff immediately report all incidents of alleged, suspected, or witnessed abuse or neglect.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A) The home's policy "Zero Tolerance of Abuse and Neglect HR-J-15" last revised December 21, 2017, stated that the investigation would include the RN initiating the "Abuse Checklist for Investigating Alleged Abuse" and they would also obtain written statements from all witnesses. The DOC, Administrator, or designate would assume the investigation lead which included obtaining written statements from all concerned parties and the resident, if able. They would also continue the checklist for reporting and investigating alleged abuse.

The "Abuse Checklist for Investigating Alleged Abuse" last revised December 2017, stated that this checklist was to be used for any suspected or actual abuse of a resident. The checklist included actions to be completed as well as indicating the person responsible, date, and signature.

The home's policy "Resident Non-Abuse LP-C-25" last revised February, 2018, stated that the Administrator would maintain confidential files that would include any statements, interviews, meeting minutes, and any other documentation generated by the investigation.

DOC #104 stated that nursing checklists were part of their policy. However, they were not written on or maintained as part of the investigation records. They said that the RN documented verbal statements in risk management; however, sometimes written statements were completed and other times not. The DOC said that management does not obtain written statements from all staff and/or the residents involved.

i) A critical incident (CI) was submitted to the Ministry of Health and Long-term Care (MOHLTC) related to an incident of alleged staff to resident abuse. The CI indicated that PSW #116 reported an incident of alleged verbal abuse to management.

The home's documentation included an untitled document that was dated the day after the alleged incident, which detailed their discussions with PSW #116 and PSW #129. The home's documentation did not contain an "Abuse Checklist for Investigating Alleged Abuse" and did not contain any written statements from witnesses.

PSW #116 said that they did not complete a written statement or discuss the incident with management after they had verbally reported their concern [728].

ii) Two CIs were submitted to the MOHLTC both related to alleged abuse. The home's investigation records did not include an abuse checklist and there were no written statements from those involved.

PSW #137 stated they were not asked and they did not complete a written statement. They also said that they were not interviewed by management

related to the incident.

RN #118 and #138 both stated that they were unaware of an abuse checklist. RN #138 said that they were to document information reported to them in the risk management section of PointClickCare (PCC). They did not investigate further and they did not interview the resident or obtain written statements from all involved. [633].

iii) A CI was submitted to the MOHLTC related to alleged staff to resident abuse.

A review of the home's investigation records did not include written statements from any of the three witnesses nor did it include the abuse checklist for investigating alleged abuse.

PSW #137, Physiotherapy Assistant (PTA) #111 and Housekeeper #126 were questioned by the management team related to the incident. There were no written statements in the home's investigation file.

Acting DOC #103 shared that they took a few notes during the investigation but did not take statements from those staff and residents involved [729].

iv) A CI report was submitted to the MOHLTC related to staff to resident abuse and neglect. The CI documented that on a specified date, resident #016 reported an allegation of improper care/neglect.

RPN #122 said that they interviewed resident #016, completed the risk management report in PCC, and notified the RN of the concern. They did not complete an abuse checklist for investigating alleged abuse and shared that they were not aware of the checklist [729].

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with related to completing and documenting alleged abuse investigations.

B) The home's policy titled "Zero Tolerance of Abuse and Neglect" last revised December 21, 2017, directed all staff members that they were obligated to

immediately report any incidents or suspected incidents of resident abuse.

i) A critical incident (CI) was submitted to the MOHLTC, related to an incident of alleged staff to resident abuse. The CI indicated that PSW #116 reported an incident of alleged verbal abuse to management.

The home's documentation related to the incident stated that PSW #116 did not immediately report the incident of alleged verbal abuse that they had witnessed.

PSW #116 said that the expectation was to report any incidents of alleged, suspected, or witnessed abuse immediately and that with this incident they did not. DOC #104 said that the expectation is that staff report incidents of alleged abuse immediately [728].

ii) A CI was submitted to the MOHLTC, related to alleged staff to resident abuse.

A review of the CI indicated that the incident occurred on a specified date. The CI documented that Administrator #102 was made aware of the incident fourteen days later.

Housekeeper #126 said that they reported the incident to the Acting DOC #103 four days later when they returned to work. Housekeeper #126 said that they should have reported it immediately after the incident occurred.

PSW #137 said Administrator #102 followed up with them regarding the incident twelve days after the incident occurred.

The Acting DOC did not know the exact date that they were notified of the incident. There were inconsistencies with the dates that the alleged incident was reported to management and there was no documentation in the investigation that identified when management became aware of the incident. DOC #104 said that staff were expected to report their allegations of witnessed or suspected abuse to the home immediately [729].

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with related to staff

immediately reporting incidents of alleged abuse. [s. 20. (1)]

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 3 as it related to five of the five incidents reviewed. The home had a level 3 history as they had on-going non-compliance with this section of the LTCHA that included:
- voluntary plan of correction (VPC) issued October 4, 2016 (2016_258519_008).

(728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 09, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Order / Ordre :

The licensee must be compliant with s.76.(2) of the LTCHA.

Specifically the licensee must:
a) Ensure that agency registered staff members #128, #138, #139, and any other agency staff, do not perform their responsibilities before receiving training in the following areas:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

b) Ensure the training is documented and the training records for agency registered staff members #128, #138, #139, any other agency staff is kept in the home.

Grounds / Motifs :

1. The licensee has failed to shall ensure that all staff at the home have received

training as required by this section.

Critical incidents related to alleged abuse were submitted to the MOHLTC.

A) LTCHA 2007, c. 8, s. 76 (2) states that the licensee shall ensure that prior to any person performing responsibilities in the home, the licensee is responsible to ensure that training is provided related to the following: the residents bill of rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; fire prevention and safety; emergency and evacuation procedures; infection prevention and control; acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities; and, any other areas provided for in the regulations

Agency staff member #128 and #138 said that upon hire they completed on-site orientation to the home. DOC #104 was unable to provide the orientation training records for Agency staff members #128, #138 and #139. The DOC said that the Agency had been contracted and were responsible to ensure that mandatory training was provided to their employees.

Agency Manager #134 said the A Supreme Nursing and Homecare Orientation Manual was the training material provided to staff working in long-term care. The orientation manual did not include the home specific policies and procedures. Staff were to review the material and sign off on completion upon hire and annually thereafter. In-services were provided for updated material only.

The Agency was unable to provide their orientation records for staff members #138 and #139.

B) LTCHA, 2007, c. 8, s. 76 (7) states that every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations including: abuse recognition and prevention; mental health issues, including caring for persons with dementia; behaviour management; how to minimize the restraining

of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations; palliative care; any other areas provided for in the regulations.

O Reg. 221. (1)(2)(3)(4) stated that staff must receive annual training in all these areas and identified the additional training requirements for all staff.

The DOC was unable to provide any annual training records for the agency staff members that had worked in the home. The DOC said the Agency was responsible to provide the annual training on the homes specific policies and procedures for their Agency staff.

Agency staff member #128 said they had not received annual training from the Agency. Agency staff member #138 said they had completed the annual training; however, they could not identify when and if this training had included the home's specific policies and procedures. The "A Supreme Nursing and Homecare Orientation Manual", dated 2018-2019, did not include any of the home's specific training material.

From March 14 to 19, 2019, the DOC said that they requested the training records for the three identified agency staff members and two additional agency staff. The Agency did not provide any annual training records to the home.

Staff abuse training records for Agency registered staff members #128, #138 and #139 were requested from the DOC. DOC #104 said that the home had contracted A-Supreme Nursing and Homecare for their Agency staff and the Agency was responsible to provide the training as set forth in the Act and regulations. The DOC said this included the home's specific policies and procedures.

The home's abuse policy "Zero Tolerance of Abuse and Neglect", last revised December 21, 2017, stated that all staff would receive in-service education on abuse and neglect upon hire and annually thereafter.

The home's policy "Resident Non-Abuse" last revised February, 2018, stated that all persons that interacted with residents on a regular basis would complete abuse intervention training (S.T.O.P program) prior to commencing work and

annually thereafter. Sign off forms would be retained in the employee file.

The home was unable to provide any additional training records in relation to the Agency staff. The DOC said that they did not maintain files for Agency staff but were aware that it was their responsibility to ensure that the training was completed.

The licensee has failed to ensure that all agency staff at the home received training as required before agency staff worked at the home and annually thereafter as set forth in the Act and regulations. [s. 76. (1)]

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 3 as it related to three of three agency registered staff reviewed. The home had a level 2 history as they had previous unrelated non-compliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 09, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Maria McGill

Service Area Office /
Bureau régional de services : Central West Service Area Office