Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2020	2020_750539_0010 (A1) (Appeal\Dir#: DR# 138)	003093-20, 009019-20	Complaint

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

Amended by Lynne Haves (Director) - (A1)(Appeal\Dir#: DR# 138)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001,CO#002.
The Director's review was completed on October 22, 2020.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 138.
A copy of the Director Order is attached.

Issued on this 26th day of October, 2020 (A1)(Appeal\Dir#: DR# 138)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by Lynne Haves (Director) - (A1)(Appeal/Dir# DR# 138)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 16-17, 20-24, 27-30, 2020.

The following intakes were completed in this inspection:

Log #003093-20 and Log #009019-120- complaints in relation to resident care.

This inspection was completed concurrently with Critical Incident System inspection 2020_750539_0011.

The inspectors toured the home and observed resident care and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping, residents and families.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift staff recorded symptoms of infection for residents #002 and #005 and took immediate action as required when the resident's health status declined.

Resident #002’s clinical records in Point Click Care (PCC) documented that the resident showed various symptoms of infection requiring ongoing monitoring and follow up actions.

i) Resident #002 was admitted to the hospital in the Winter of 2019 with signs and symptoms of a severe infection.

Resident #002's progress notes in the weeks leading up to the hospitalization did not document the signs and symptoms of infection that the resident was diagnosed with on admission to hospital, though they were receiving oral antibiotics to treat a related medical condition.

The Director of Care could not locate further monitoring documentation in relation to that type of infection for that time frame.

ii) Resident #002's progress notes from the Fall-Winter of 2019, documented that the resident had wounds that showed signs and symptoms of infection.

Three staff recalled that one of resident #002's wounds appeared to be infected.

The home’s "Wound Care Protocol" instructed staff to swab for Culture and Sensitivity (C&S) as directed by the Wound Care Specialist if there were signs of infection.

No wound C&S laboratory results could be located on resident #002's chart or by the DOC.

iii) Progress notes in the Fall of 2019, documented that resident #002 had coughing spells when eating.

In late Fall of 2019, resident #002's clinical records documented that the resident was very hot and sweaty at meal time. There was no documented temperature in PCC.

Later in 2019 resident #002 developed a productive cough.

The Registered Dietitian (RD) could not recall any respiratory assessment by the multidisciplinary team in relation to the resident's coughing spells during meals and concerns brought forward by staff, during that time period.

iv) In the Fall of 2019, resident #002 was described as exhibiting signs of an eye infection. Registered staff ordered warm compresses to the eye for three days before an antibiotic was ordered.

v) In the Fall of 2019, resident #002 was described as having a rash. Progress notes described that it took two weeks for the referral and diagnosis and the order of prescription cream to treat the skin infection.

The DOC stated that the home did not have a decision tree for staff to determine what steps to take if the resident developed various symptoms of infection requiring immediate action to be taken. [s. 229. (5) (b)]

2. The home’s emergency transfer records documented that on a day in 2020, resident #005 was transferred to the hospital for a specified medical diagnosis and their transfer could have been avoided.

Resident #005’s clinical records documented that the resident was admitted to the hospital, with a change in their health status and required specialized treatment.

DOC #101 said that if a resident displayed signs of infection, staff were expected to complete focused assessments, vital signs and to contact the physician for further directions if the condition did not improve with the initial interventions.

Resident #005's clinical records documented that the resident required ongoing monitoring of their medical condition.

i) On an identified date, clinical records documented that resident #005 had specified symptoms of infection and needed monitoring. No further monitoring or follow up actions were taken for four consecutive evening and night shifts.

DOC #101 said that there was no other documentation of the actions taken to monitor resident #005's specified symptoms.

ii) Three days later, a progress note documented that resident #005 showed symptoms of a specified infection and further investigation was needed.

RPN #106 said they could not recall if the specified diagnostic test was completed.

Review of resident #005's clinical records found no record of the specified test or other documentation of the monitoring for symptoms of the resident's medical condition.

DOC #101 said they expected staff to continue to monitor and record symptoms of the specified infection and to complete the required diagnostic tests. They could not locate a record of the tests report for that time period.

iii) On an identified date, resident #005's progress notes documented that the resident's health condition declined and required ongoing monitoring.

The next day, a progress note documented that resident #005 was to have specialized monitoring as their health condition worsened. Nine hours later, the physician was notified, and they ordered registered staff to initiate a different monitoring process and to transfer the resident to the hospital immediately if symptoms were displayed or worsened.

Review of resident #005's medical records showed no documentation that the physician's order was implemented.

Resident #005's health condition continued to deteriorate in the next 24 hours prior to their transfer to the hospital.

RPN #106 said that the physician's order was not processed by the registered staff. They said that the resident should have been transferred to the hospital earlier as their health condition was declining.

DOC #101 acknowledged the inconsistencies in the actions taken to address the changes in resident #005's health condition, and the gaps in the communication and documentation amongst nursing staff.

The licensee has failed to ensure that on every shift staff recorded symptoms of infection in residents #002 and #005 and took immediate action, as required. [s. 229. (5) (b)] (758)

Additional Required Actions:

(A1)(Appeal/Dir# DR# 138)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

i) Resident #002’s care plan stated they had a healed wound from 2018. In the summer of 2019, the resident was identified as having skin breakdown of the wound. However, a request for treatments was not made to the registered staff until over four weeks later, at which time the order for treatment and a weekly skin assessment began. The wound had declined.

ii) In the Fall of 2019, resident #002's progress notes documented the resident was having pain during wound dressings. No Pain Assessment Tool was completed in relation to the increased pain.

iii) When the wound declined in the fall of 2019, a referral was made to the Registered Dietitian (RD) who assessed the resident as not needing additional nutritional supplements for wound healing at that time. Dietary interventions were implemented two months later.

The RD stated that they had monitored the resident regularly and felt their oral

intake was good initially, however, they acknowledged that a missing monthly weight and a late weight another month, may have delayed the identification of the resident's weight loss and the additional need for wound healing supplements.

iv) The wound continued to decline. No C&S swab was completed on the wound and no antibiotics were ordered to treat the signs and symptoms of infection.

Three staff recalled that resident #002's wound appeared to be infected and had progressively worsened.

Registered staff stated that obtaining a C&S swab was a medical directive the staff could complete.

Chart review and review of lab work by the DOC did not locate any C&S wound swabs.

The home failed to ensure that resident #002's wound received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #002’s care plan stated they had a healed stage X wound from 2018.

In the summer of 2019, a Wound Care Specialist Referral was completed when resident #002 developed altered skin integrity in the area of the healed wound.

Later in the summer of 2019, the resident was again identified as having altered skin integrity in the area of the previously healed wound.

The wound then declined.

A request for dressing treatments was made to the registered staff over four weeks later.

No documented weekly skin and wound assessments for the altered skin integrity were completed until that date, at which time weekly skin assessments began.

The home's "Wound Care Protocol" stated that the stage X wound should be scheduled for weekly assessment on the eTAR.

Three staff recalled resident #002's wound. They stated it was not healing, and progressively worsened.

The skin and wound assessments were not completed weekly for four weeks.

The home failed to ensure that resident #002's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 138)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Makers (SDMs) were provided the opportunity to participate fully in the development and implementation of the plan of care.

i) A complaint was submitted to the MLTC regarding the lack of opportunity for the SDMs to participate in resident #002's end of life care in the Winter of 2019.

A Palliative and End-of-Life Assessment was completed by a RN for resident #002.

Upon review, the plan of care was not changed in relation to the resident's palliative status. No further communication was documented with either of the resident's SDM's in regards to the resident's declining health status and any changes required to the plan of care.

The RN could not state who they spoke to in regards to the completed Palliative and End-of-Life Assessment stating they spoke to various family members at different times.

A written summary of a conversation between the Administrator and the family acknowledged that there could have been better communication between the staff and the SDMs in relation to the resident's palliative status and necessary plan of care interventions to be implemented.

The licensee failed to ensure that the designated SDMs for resident #002 were provided an opportunity to participate fully in the development and implementation of the plan of care in regards to resident #002’s palliative designation, declining health status and changing care needs.

ii) Resident #003 was transferred to hospital in Spring of 2020, and was hospitalized.

Progress notes documented that the family had not been notified of the transfer and hospital admission of resident #003. They spoke to the Director of Care with their concerns.

The DOC confirmed that the family should have been contacted by staff, the family had not been notified, and that the DOC had provided training to staff to remind them to contact the resident's family/SDMs for any changes to the resident's condition and the resident's plan of care.

The licensee failed to ensure the designated SDMs for resident #003 were provided an opportunity to participate fully in the development and implementation of the plan of care.

The licensee has failed to ensure residents #002 and #003's Substitute Decision Makers (SDMs) were provided the opportunity to participate fully in the development and implementation of the plan of care when the resident's health status changed. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #002 fell while being transferred and suffered an injury.

Resident #002's clinical records described how the resident had fallen, after the staff had used the improper procedure for transfers.

Two staff recalled the fall when staff used the improper procedure for transfers.

The licensee has failed to ensure that resident #002's plan of care for all transfers was followed. [s. 6. (7)]

3. The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when resident #002's care needs changed.

Resident #002 fell in early 2019 and was diagnosed with a specified condition.

Resident #002's plan of care was not revised to list the condition under the medical diagnoses and their care plan was not updated.

Resident #002 sustained another fall eight months later.

Resident #002's progress notes documented the resident was in pain after the second fall, especially with movement.

Two registered staff were unable to locate the revised plan of care in relation to the resident's condition, which included interventions to address the condition. They were unable to explain how a new staff member would have known about the resident's condition and the need to reassess the resident after the second fall.

The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when resident #002's care needs changed in relation to their falls and new condition. [s. 6. (10) (b)]

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 6. (5) that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care; 6. (7) that the care set out in the plan of care is provided to the resident as specified in the plan; and 6. (10) ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan is met; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The following is further evidence to support the order issued on October 30, 2019, during Critical Incident System inspection 2019_800532_0012 to be complied January 6, 2020 with a compliance date of February 4, 2020.

i) Resident #002 sustained a fall with injury in early 2019. The resident's injury was diagnosed four weeks after the fall. No full Pain Assessment Tool was completed in Point Click Care (PCC) in relation to the increased pain until their diagnosis.

Registered staff recalled concerns raised by resident #002's family about the resident's pain after the fall.

ii) Resident #002 sustained a fall in the Fall of 2019, with increased pain documented afterwards.

No Pain Assessment Tool was completed in PCC in relation to resident#002's increased pain.

iii) Resident #002 began having difficulty swallowing pain medications later in 2019.

A Pain Assessment Tool was not completed initially during that time period.

The home's policy, "Pain Management-PM-N-20", revised January 2018, stated that a clinically appropriate instrument should be used when a resident exhibited a change in health status or pain was not relieved by initial interventions.

Three registered staff stated the home's process for the completion of a pain assessment was when there was new pain, the staff did a pain screening for three days in the eMAR for a resident injury or for medication changes.

The DOC acknowledged there were no Pain Assessment Tools in PCC completed for resident #002 at the above noted times.

The home failed to ensure that when resident #002's pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.

There were no documented monthly weights for resident #002 for three months in 2019.

Between one missed monthly weight and a delayed weight the next month resident #002 lost 8.5 Kg.

The home's policy, "Weight Management-DTY-014", revised October 2017, stated that the resident's weight was to be taken monthly no later than the tenth day of the month, and nursing staff were to reweigh a questionable weight change of 2.5 kg to verify accuracy.

PSWs stated weights were done at the beginning of the month usually on bath days, using the bath scale, and also completed with a significant change.

A RN stated that monthly weights were documented in PCC but could not locate the weights.

The licensee failed to ensure there was a weight monitoring system implemented to measure and record resident #002's weight on a monthly basis. [s. 68. (2) (e) (i)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they report in writing to the Director in relation to any of the incidents described in r. 107 (1), (3) or (3.1), within 10 days of becoming aware of the incident, that included: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

Resident #002 sustained a fall in early 2019 after the staff had used the improper procedure to transfer the resident. Two staff recalled the fall when staff used the improper procedure for transfers.

The resident sustained an injury, was sent to the hospital, and returned to the LTC home.

A review of the Critical Incidents submitted by the home was completed to see if the home had submitted a Critical incident Report under one of the two submitting categories:
i. Improper/Incompetent treatment of a resident that results in harm or risk of harm to the resident 24.(1)(1) or
ii. An incident that caused an injury to the resident for which the resident is taken to hospital and which results in a significant change in the resident's health status 107.(3)(4)

No Critical Incident Report had been submitted by the home in relation to the resident's improper transfer with fall and injury.

The DOC stated that a Critical Incident should have been submitted if there was a change in a resident's function from their base line and an investigation should have been completed as to why the incident occurred. However, the DOC was not in the home at the time, and could not comment as to why a Critical Incident report was not submitted.

The licensee has failed to ensure to make a report in writing to the Director regarding the improper transfer of resident #002 including a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. [s. 107. (4) 1.]

Issued on this 26th day of October, 2020 (A1)(Appeal/Dir# DR# 138)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Lynne Haves (Director) - (A1) (Appeal/Dir# DR# 138)
Inspection No. / No de l'inspection :	2020_750539_0010 (A1)(Appeal/Dir# DR# 138)
Appeal/Dir# / Appel/Dir#:	DR# 138 (A1)
Log No. / No de registre :	003093-20, 009019-20 (A1)(Appeal/Dir# DR# 138)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 26, 2020(A1)(Appeal/Dir# DR# 138)
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 Long-Term Care

Ministère des Soins de longue durée

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

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(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

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

(A1)(Appeal/Dir# DR# 138)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

(A1)(Appeal/Dir# DR# 138)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

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

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

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

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 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:

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

Ordre(s) de l'inspecteur

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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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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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 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 26th day of October, 2020 (A1)(Appeal/Dir# DR# 138)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Lynne Haves (Director) - (A1)
(Appeal/Dir# DR# 138)

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