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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## Public Copy/Copie 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 |
|---|---|---|---|
| Jan 5, 2021 | 2020_738753_0032 | 023334-20 | 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

KATHERINE ADAMSKI (753)

## 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): December 14 -17, 2020**

**The following Critical Incident System (CIS) intake was completed during this inspection:**
**-Log #023334-20 related to falls prevention and management**

**This CI inspection was conducted concurrently with Follow-Up Inspection #2020_738753_0030 and Director's Order Follow-Up Inspection #2020_738753_0031.**

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

**The inspector also toured the home, observed resident care provision and completed record reviews.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the home's Post Fall Management Procedure was complied with for a resident.

O. Reg. 79/10, s. 30, states that a written description of each interdisciplinary program required under section 48 of this Regulation, including falls prevention and management, is required and must provide methods to reduce risk and monitor outcomes of residents.

The home's Post Fall Management Procedure directed staff to initiate a head injury routine (HIR) for resident's who had an unwitnessed fall.

A resident had an unwitnessed fall and a HIR was not initiated as per the home's procedure. Staff stated that a HIR should have been initiated in response to the unwitnessed fall.

There was minimal risk of harm to the resident resulting from staff not initiating a HIR.

Sources: Strathcona Post Fall Management Procedure, resident medical chart including assessments and progress notes, and staff interviews. [s. 8. (1) (a),s. 8. (1) (b)]

**Issued on this 6th day of January, 2021**

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|---|
| **Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs** |

**Original report signed by the inspector.**