Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 16, 2023	
Inspection Number: 2023-1020-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Sharon Farms & Enterprises Limited	
Long Term Care Home and City: Strathcona Long Term Care, Mount Forest	
Lead Inspector Brittany Nielsen (705769)	**Inspector Digital Signature** Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2023.05.16 15:57:20 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
April 19-21, 24-28, May 1-2, 2023.

The following intake(s) were inspected:

- Intake: #00020242 related to staff to resident abuse.
- Intake: #00020843 [Complaint] related to food production, resident abuse and neglect, and long wait times.
- Intake: #00021501 related to a disease outbreak.
- Intake: #00086755 related to resident neglect.

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

Continence Care
Food, Nutrition and Hydration

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: Coronavirus Disease 2019 (COVID-19) response measures for long-term care (LTC) homes, the licensee was required to ensure that the Ministry of Health (MOH) COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units was followed. The MOH COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units referenced the Public Health Ontario fact sheet, Selection and Placement of Alcohol Based Hand Rub (ABHR) during COVID-19 in LTC and Retirement Homes, which states not to use expired product and to note product expiration date when selecting the product.

During the inspection, four bags of ABHR in dispensers were observed on three floors with expiry dates of August 2020 and November 2022. Three other bags of ABHR in dispensers were observed in an activity room, training room, and common area with expiry dates of February 2023 and August 2020 respectively.

No staff or residents were observed using the expired ABHR and the expired product was replaced with active ABHR. There was no impact and low risk to the residents and staff for infection as there was active ABHR available throughout the home to be used.

Sources: observations, Minister's Directive: COVID-19 response measures for LTC homes, effective August 30, 2022, MOH COVID-19 Guidance: LTC Homes and Retirement Homes for Public Health Units, Version 10, dated March 21, 2023, Public Health Ontario: COVID-19 Selection and Placement of ABHR during COVID-19 in LTC and Retirement Homes dated November 6, 2020, interviews with staff.

[705769]

Date Remedy Implemented: April 20, 2023

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from verbal abuse by a staff member.

Ontario Regulation 246/22, s. 2 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary:
The home became aware of an incident where a staff member made a belittling comment to a resident while providing care. The comment left the resident feeling angry and several staff said the resident was visibly upset while speaking about the incident.

By failing to protect a resident from verbal abuse, there was risk of diminishing the resident's dignity.

Sources: Critical incident report, home's investigation notes, interview with a resident, and interviews with staff.

[705769]