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
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Original Public Report

Report Issue Date: October 19, 2023	
Inspection Number: 2023-1020-0007	
Inspection Type: Critical Incident	
Licensee: Sharon Farms & Enterprises Limited	
Long Term Care Home and City: Strathcona Long Term Care, Mount Forest	
Lead Inspector Diane Schilling (000736)	**Inspector Digital Signature** Diane Schilling Digitally signed by Diane Schilling Date: 2023.10.24 09:15:35 -04'00'
Additional Inspector(s) Tanya Murray (000735) Jessica Bertrand (722374) was present during the inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10-13, 2023

The following intake(s) were inspected:

- Intake: #00090888 related to fall prevention and management
- Intake: #00090987 related to fall prevention and management

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee failed to ensure that a resident was reassessed and their plan of care was reviewed and revised when the care set out in the plan has not been effective.

Rationale and Summary
A resident was at risk of falls. A specific intervention identified in their plan of care was to be used. It was observed to be not in place multiple times.

A Registered staff said the intervention was not longer being used. It was not an effective intervention should have been reviewed.

The resident was at risk when interventions were not reviewed or revised when the plan was not effective.

Sources: Observations, clinical records and interviews with staff
[000736]

WRITTEN NOTIFICATION: Plan of care
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other and implement the plan of care, so they are consistent and complement each other.

Rationale and Summary
A resident's new diagnosis was not communicated with the physician. This was not discovered until the co-DOC reviewed the resident's clinical record.

The co-DOC stated that this delay could have changed the care provided to the resident, which could include interventions to make the resident more comfortable.

Failure to communicate amongst staff and collaborate with the doctor increased the risk of harm for the resident.

Sources:
Resident clinical record, interviews with staff
[000735]

WRITTEN NOTIFICATION: Transferring and positioning techniques
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when transferring a resident.

Rationale and Summary
Two staff assisted a resident back to their room using a mobility device incorrectly.

The co-DOC stated the transfer was not safe way.

The resident was at risk of harm when they were improperly transferred.

Sources:
Resident health care records, interviews with staff
[000736]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that a post-fall assessment was completed.

Rationale and Summary
A resident fell. No post-fall assessment was completed after the incident.

The co-DOC said the assessment should have been completed for the resident.

Failure to complete a post-fall assessment using a clinically appropriate assessment instrument may have resulted in injuries not being identified.

Sources:
Resident's clinical record, interviews with staff
[000735]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Rationale and Summary
The IPAC Standard for LTCHs, dated April 2022, section 3.1(i), indicates that the licensee shall ensure that surveillance actions are taken to regularly monitor for symptoms including but not limited to, fever, new coughs, vomiting, and diarrhea, and take appropriate action.

A resident was noted by staff to be exhibiting signs and symptoms of an infection. They were to obtain a diagnostic sample for testing, but not samples were ever collected.

Two staff members said that they should have collected a diagnostic sample for a proper diagnosis.

The Resident was at risk for delayed treatment when the home did not take action as ordered by the physician.

Sources:
Resident clinical record, interview with staff
[000735]