Ontario

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

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

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ✕ **Public Copy/Copie Public**
Name of Director:	Lynne Haves
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ✕ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	003093-20, 009019-20
Original Inspection #:	2020_750539_0010
Licensee:	Sharon Farms & Enterprises Limited 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home:	Strathcona Long Term Care 720 Princess Street, MOUNT FOREST, ON, N0G-2L3
Name of Administrator:	Cate MacLean

Background:

Ministry of Long-Term Care (MLTC) Inspectors #539, #758 and #767 conducted a complaint inspection at Strathcona Long-Term Care (the Home) on the following dates: July 16, 17, 20-24, and 27-30, 2020.

Intake logs #003093-20, #009019-120 were inspected during this complaint inspection. A critical incident inspection (#2020_750539_0011) was conducted concurrently with the complaint inspection.

As part of the complaint inspection, the Inspectors found that the Licensee, Sharon Farms & Enterprises Limited (the Licensee), failed to comply with s. 229 (5) (b) and s. 50 (2) (b) (ii) and (iv) of Ontario Regulation 79/10 (Regulation) under the LTCHA.

Pursuant to s. 153(1)(a) of the LTCHA, Inspectors #539, #758 and #767 issued the following two compliance orders for the above findings of non-compliance:

Compliance Order #001 relates to s. 229 (5) (b) of the Regulation and reads as follows:

"The licensee must be compliant with O. Reg 79/10, s. 229 (5) (b) of the Act.

Specifically, the licensee must:

(a) Ensure that when resident #005 exhibits symptoms of infection, the symptoms are recorded, monitored and immediate action is taken as required.
and
(b) Ensure that all registered staff employed by the LTC home are retrained in the process for monitoring residents' symptoms of infection and the immediate action to take including notifications and documentation. A record of the content of the training and the attendance of registered staff is to be kept in the home."

Compliance Order #002 relates to s. 50 (2) (b) (ii) and (iv) of the Regulation and reads as follows:

"The licensee must be compliant with O. Reg 79/10, s. 50 (2) (b) (ii) and (iv).

Specifically, the licensee must:
a) Ensure that when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, they receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.
b) Are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated."

Order #:	001

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

Pursuant To:

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).

Order:

The licensee must be compliant with O. Reg 79/10, s. 229 (5) (b) of the Act.

Specifically, the licensee must:

(a) Ensure that when resident #005 exhibits symptoms of infection, the symptoms are recorded, monitored and immediate action is taken as required.
and
(b) Ensure that all registered staff employed by the LTC home are retrained in the process for monitoring residents' symptoms of infection and the immediate action to take including notifications and documentation. A record of the content of the training and the attendance of registered staff is to be kept in the home.

Grounds:

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.

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

i) 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.

ii) 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.

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.

iii) 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.

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. 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 #005ss specified symptoms.

ii) 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)

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 2 history as they had on-going non-compliance with other sections of the LTCHA that included 4 previous compliance orders.

This order must be complied with by:	November 30, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 26th day of October, 2020	
Signature of Director:	
Name of Director:	Lynne Haves