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

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Original Public Report

Report Issue Date: December 6, 2022	
Inspection Number: 2022-1020-0002	
Inspection Type: Critical Incident System	
Licensee: Sharon Farms & Enterprises Limited	
Long Term Care Home and City: Strathcona Long Term Care, Mount Forest	
Lead Inspector Robert Spizzirri (705751)	**Inspector Digital Signature** Robert Spizzirri Digitally signed by Robert Spizzirri Date: 2022.12.07 08:54:38 -05'00'
Additional Inspector(s) Blake Webster (000689)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 28-30, and December 1-2 of 2022

The following intake(s) were inspected:

- Intake: #00004517 related to fall prevention and management
- Intake: #00006085 related to resident care and support services

The following intakes were completed in the Critical Incident System Inspection:
Log #00004039 and Log #00005366 were related to falls.

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

Infection Prevention and Control
Falls Prevention and Management
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10 s. 36

The licensee has failed to ensure that staff used safe positioning techniques while assisting a resident.

Rationale and Summary

A staff member portered a resident without footrests, resulting in injury.

The DOC said that residents who are portered in a wheelchair must have their feet safely positioned by footrests because of the risk of injury.

When staff failed to position the resident safely in the wheelchair, the resident was injured.

Sources: Critical incident report, resident's progress notes and other health records, interview with DOC and other staff.

[705751]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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 implement any standard or protocol by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, April 2022, section 10.4, states that "the Licensee shall ensure the hand hygiene program includes policies and procedures as a component of the overall IPAC Program, as well as: h) support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting; and i) support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments".

On November 28, 2022, 21 residents were observed to enter the dining room for a meal service. All 21 residents were not encouraged and/or assisted with hand hygiene prior to eating.

The IPAC lead said that staff were expected to assist residents with hand hygiene prior to eating.

A PSW said they were not aware of the home's expectations.

The home's Hand Hygiene Program (IC-D-40) did not include procedures to support residents with hand hygiene prior to eating.

The IPAC lead said there were no written policies and/or procedures regarding support for residents to perform hand hygiene prior to eating.

When there are no written procedures in place as required in the IPAC Standard (April 2022), required tasks are at risk of not being completed, and the risk of infection transmission increases.

Sources: Observations on November 28, 2022, Hand Hygiene Program policy IC-D-40, interview with IPAC Lead, and other staff.

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