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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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: June 18, 2024

Inspection Number: 2024-1020-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Sharon Farms & Enterprises Limited

Long Term Care Home and City: Strathcona Long Term Care, Mount Forest

Lead Inspector	**Inspector Digital Signature**
Alicia Campbell (741126)	Alicia Campbell Digitally signed by Alicia Campbell Date: 2024.06.25 15:01:33 -04'00'

Additional Inspector(s)
Sharon Perry (155)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6-10, 14-17, 21, 23-24, 27, 2024.

The following intake(s) were inspected:

- Intake #00112729, CI #3051-000004-24 - related to abuse of a resident.
- Intake #00112789 - Complaint regarding care of a resident.
- Intake #00113400 - Complaint regarding allegations of abuse towards staff and residents.
- Intake #00114103 - Complaint regarding improper care of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident or a resident's substitute decision-maker were given the opportunity to participate fully in the development and implementation of the resident's plan of care regarding their wheelchair.

Rationale and Summary
It was identified that a resident's mobility aide needed a repair.

The resident indicated someone had been in to look at their mobility aide to determine what needed to be repaired, but they had never received any answers.

The Director of Therapeutic Recreation indicated the resident's mobility aide had not

been repaired at the direction of the facility.

Failure to involve the resident or their substitute decision maker in the implementation of the resident's plan of care regarding their mobility aide, left the resident and substitute decision maker without information about the required repairs and why they were being delayed.

Sources: A resident's progress notes; mobility aide book documentation, Director of Therapeutic Recreation Emails; Interviews with resident and staff.

[741126]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary

a) A Registered Nurse (RN) reported to the Director of Nursing (DON) that a resident reported that a Personal Support Worker (PSW) inappropriately touched them. The next day, the DON spoke with the resident who reported the same allegation of abuse.

This was not reported to the Director.

Not reporting the incident immediately to the Director did not allow the Ministry of Long-Term Care an opportunity to follow up.

Sources: Critical Incident Report System, CI report 3051-000004-24, interviews with staff.

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b) When a PSW answered a residents call bell, the resident was emotional and stated that another PSW had inappropriately touched them. This was reported to an RN.

The incident of alleged abuse was not reported to the Director at the Ministry of Long-Term Care until the next day.

Sources: Critical Incident Report System, CI report 3051-000004-24, interviews with staff.

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WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee failed to ensure that a Personal Support Worker (PSW) and a Registered Nurse (RN) received training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

Rationale and Summary
a) The Director of Nursing (DON) shared that agency staff did not complete learning modules on Surge Learning but did complete a read and sign off of the home's policies including the home's policy to promote zero tolerance of abuse and neglect.

The DON was not able to provide an Agency Staff Education Sign Off form for the PSW.

b) During an interview with an RN they shared that they completed their orientation education on Surge Learning. They did not recall it including the home's policy to promote zero tolerance of abuse and neglect.

The DON reviewed Surge Learning modules regarding abuse and stated that it did

not include the home's policy to promote zero tolerance of abuse and neglect of residents.

The RN not having received training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities, may have been a contributing factor in the delay of reporting, documenting and investigating the allegation of abuse related to a resident.

Sources: review of Agency Staff Education Sign Off forms, review of Surge Learning education records for staff, interviews with staff.

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WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee failed to ensure that staff received retraining annually on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
The Executive Director stated that staff were educated annually using Surge Learning on the home's policy to promote zero tolerance of abuse and neglect of residents.

The Director of Nursing reviewed Surge Learning modules regarding abuse and stated that it did not include the home's policy to promote zero tolerance of abuse and neglect of residents.

Staff not having annual education on the home's policy to promote zero tolerance of abuse and neglect put residents at risk of staff not reporting, documenting and completing investigations into allegations of abuse as per the home's policy.

Sources: Review of Surge Learning modules regarding abuse with the DON, Surge Learning Education History reports for staff, and interview with the DON.

[155]

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident was transferred to the hospital. No assessments of the resident were

documented regarding the resident's condition or a medical reason for this transfer.

A Registered Nurse (RN) indicated that when a resident is sent to the hospital, an assessment should be completed on them including the residents' vitals and how the resident is presenting. The RN found no assessments documented for the resident's transfer to hospital.

When an assessment of the resident was not documented, the resident's condition prior to going to hospital and the reason the resident was sent to hospital was unclear.

Sources: a resident's progress notes, assessments, vitals tab; Interviews with staff.

[741126]

WRITTEN NOTIFICATION: Designated lead

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 258
Designated lead
s. 258. The licensee shall ensure that there is a designated lead for the training and orientation program.

The licensee failed to ensure that there was a designated lead for the training and orientation program.

Rationale and Summary
The Director of Nursing stated that the home did not have a designated lead for the training and orientation program.

Failure of the licensee to ensure that there was a designated lead for the training and orientation program put residents at risk as there was no lead to oversee that training and orientation was completed and that the training/orientation included all required elements.

Sources: interview with the DON.

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COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Ensure that the identified resident is provided their preferred method of bathing twice weekly. Document this conversation and the outcome on the resident's plan of care.
b) Ensure that the identified resident is provided with an individualized toileting plan that meets their care needs and preferences. Document their preferences and the

outcome on the resident's plan of care.
c) Consult with the identified resident and their substitute decision maker regarding the residents mobility aide repairs. Document this conversation and the steps that will be taken to address the mobility aide repairs in the resident's plan of care.
d) Acquire equipment that can safely transfer the identified resident and have that equipment readily available in the building at all times.

Grounds
The licensee has failed to ensure that every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

Rationale and Summary
A resident had a change in status and required a specific type of transfer equipment. Approximately a week later it was identified the resident's mobility aide needed repairs. Approximately two weeks after this, the resident's mobility aide repairs were put on hold as the facility was unsure if the mobility aide was still suitable for the resident. The resident had a significant change in their lifestyle due to the home not having the appropriate transfer equipment to meet their needs.

During the inspection the resident stated they felt frustrated about their significant change in lifestyle. They understood it was going to cost the facility money to get the equipment required to care for them, but it seemed like the facility just didn't want to do it. If the home had the proper equipment, the resident felt they would be able to have a better quality of life.

Due to the home not repairing or replacing the transfer equipment or mobility aide, the resident had a change in their lifestyle that reduced their quality of life.

Sources: a resident's clinical records; interview with resident and staff.

[741126]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #002 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Conduct weekly audits to ensure that the home's zero tolerance of abuse and neglect policy is followed for all incidents of alleged, suspected or witnessed abuse. The audits must include a date, record of the incident, indicate any deficiencies, and document any follow up actions completed, the name and designation of the person conducting the audit. The audit will be completed for a two month period or until there are no deficiencies identified.

Grounds
The licensee failed to protect two residents from abuse by a Personal Support Worker (PSW).

Rationale and Summary

a) The Director of Nursing (DON) was informed by an RN that a resident reported they were inappropriately touched by a PSW. The PSW continued to work with other residents and the next day they were told not to work on the floor the resident resided on.

Approximately a month later, the resident saw the PSW on their floor and reported to the nurse that the PSW was not to be on the floor.

b) A resident rang their call bell and a PSW answered the call bell. The PSW shared that the resident was emotional and scared, and stated that another PSW had touched them inappropriately. The PSW reported this to an RN.

After the first reported incident of alleged abuse, the alleged PSW continued to work in the home on two of the three floors without any additional supervision and residents were not protected from abuse. Two residents were not protected from abuse a PSW.

Sources: review of clinical records of residents, review of home's investigation notes, CI report 3051-000004-24, review of PSW schedules, interviews with residents and staff.

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This order must be complied with by September 6, 2024

COMPLIANCE ORDER CO #003 Policy to promote zero tolerance

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Ensure that all new staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.
b) Ensure that all existing staff, including the management team are provided education on the LTCH's policy to promote zero tolerance of abuse and neglect and any other policies or protocols referenced in the home's abuse policy. Document the education including the date, format and staff attending the training, including the staff member who provided the education.
c) Ensure all members of the management team are provided education in relation to their role and responsibilities for reporting allegations of abuse of a resident to the Director immediately, specifically what constitutes an allegation of the specific types of abuse.
d) Ensure that there is a designated lead for the training and orientation program and that there are written roles and responsibilities for this lead.

Grounds
The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with when two residents reported allegations of abuse by a Personal Support Worker (PSW).

Rationale and Summary

a) A Registered Nurse (RN) informed the Director of Nursing (DON) about an allegation of abuse. The resident was not interviewed until the next day.

On the date of the alleged incident, there was no assessment done or progress notes written that the resident was assessed related to the alleged incident of abuse and any potential injury. The Checklist for Reporting and Investigating Alleged Abuse was not initiated. No Risk Management report was completed for the resident. The physician and the police were not notified.

The Director was not immediately notified of the alleged abuse of the resident. No CI was completed regarding the resident reporting an allegation of abuse. The PSW was not placed on immediate investigative leave and continued to work into the next day before being notified of the allegation.

There was no offering of emotional counselling and support to the resident.

b) A PSW reported an allegation of abuse to an RN. The RN did not call the manager on call but reported it to another RN during report the next day. The resident was not interviewed regarding the incident of alleged abuse until the next day. The homes policy indicates immediately upon notification of an alleged incident of abuse the Executive Director, DOC or designate should obtain statements from all concerned parties, including the resident, if they are able.

On the date of the alleged incident, there was no assessment done or any progress notes written that the resident was assessed related to the allegations of abuse and any potential injury. The Checklist for Reporting and Investigating Alleged Abuse was not initiated. A Risk Management report was initiated the day after the alleged incident, but did not include any assessment for 72 hours post-incident. The

physician was not notified.

The Director was not notified of the alleged abuse of the resident by a PSW until the day after the incident. Statements were not obtained from the PSW or the RN who reported the incident. The police were not notified of the allegation of abuse of the resident by a PSW until the next day. No additional emotional counselling or support was offered to the resident.

The alleged PSW did not receive education and training to the home's zero tolerance of abuse and neglect policy. The Surge Learning Platform did not include the home's Zero Tolerance of Abuse and Neglect policy for orientation or annual training.

The home's Zero Tolerance of Abuse and Neglect Policy was not followed at numerous points including immediately reporting to the management of the home, the Director and police; assessment of residents and support of the alleged victims, immediate investigation of the incidents, and education of all staff on orientation and annually to the policy.

Sources: residents clinical records, homes investigation notes, CI # 3051-000004-24, schedule for a PSW, training records for staff, Surge Learning content review for abuse, Zero Tolerance of Abuse and Neglect Policy (LP-C-01 revised March 1, 2024), Checklist for Investigation of Actual, Suspected , or Alleged Abuse and/or Neglect (LP-C-01a) interviews with residents and staff.

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This order must be complied with by September 6, 2024

COMPLIANCE ORDER CO #004 Licensee must investigate, respond and act

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Conduct an audit of all critical incidents submitted to the Director from December 11, 2023, up to June 3, 2024, of alleged, suspected or witnessed abuse to ensure an investigation was immediately commenced. The audit must include a record of the incidents, whether an investigation was commenced immediately for these incidents, and what corrective actions were taken. Record the date of the audit, the name and designation of the person conducting the audit, and any follow up actions completed.
b) Ensure all RNs and managers are provided education in relation to when and how an investigation for an allegation of resident abuse is to occur. This training should include a review of the home's checklist for Investigation of Actual, Suspected , or Alleged Abuse and/or Neglect. A record of this training must be kept in the home and include the date and time training was provided, attendees and outline of the course content.

Grounds

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, was immediately investigated when the home became aware of the allegations of alleged abuse of three residents.

Rationale and Summary

a) A Registered Nurse (RN) reported to the Director of Nursing (DON) an allegation of abuse by a PSW towards a resident. The resident and the alleged PSW were not interviewed regarding the alleged abuse until the next day.

b) A resident was observed emotional and reported an allegation of abuse related to a PSW. This was reported to a RN. The RN did not call the manager on call but reported it to another RN during report the next day. The resident was not interviewed regarding the incident of alleged abuse until the next day.

Not immediately investigating allegations of abuse put other residents at risk of being abused as the alleged PSW continued to work in the home.

Sources: review of residents clinical records, Risk Management report, home's interview notes, CI 3051-000004-24, schedules for a PSW, interviews with residents and staff.

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c) A critical incident report was submitted to the Ministry of Long-Term Care for the financial abuse of a resident by a visitor.

The Executive Director stated the home did not complete an internal investigation

into this incident. The Executive Director was unable to provide the name of the individual who allegedly financially abused the resident.

Sources: a resident's progress notes and documents, CI #3051-000003-24; Interviews with staff.

[741126]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #005 Licensee must investigate, respond and act

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Conduct an audit of all critical incidents submitted to the Director from December 11, 2023 to June 3, 2024, of alleged, suspected or witnessed abuse to ensure that appropriate action was taken in response to every such incident. The audit must include a record of the incidents, whether appropriate action was taken in response to every such incident, and what corrective actions were taken. Record the date of the audit, the name and designation of the person conducting the audit, and any

follow up actions completed.
b) Ensure all RNs and managers are provided education in relation to what appropriate actions are to be taken for every alleged, suspected or witnessed incident of abuse of a resident. A record of this training must be kept in the home and include the date and time training was provided, attendees and outline of the course content.

Grounds
The licensee failed to ensure that appropriate action was taken when a resident reported an allegation of abuse by a Personal Support Worker (PSW).

Rationale and Summary
A Registered Nurse (RN) reported to the Director of Nursing an allegation of abuse from a PSW towards a resident.

The alleged PSW worked on the date of the allegation and into the following day. The alleged PSW was not interviewed regarding the allegation until the following day.

The alleged PSW was allowed to continue working in the home despite the allegation of abuse being reported to the DON. The alleged PSW was not sent home on an investigative leave. An investigation was not conducted as per the home's zero tolerance of abuse and neglect policy.

Sources: interviews with a resident and staff, review of PSW schedule for the alleged PSW, review of home's policy zero tolerance of abuse and neglect (LP-C-01 and LP-C-01a).

[155]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #006 Nutritional care and hydration programs

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

The inspector is ordering the licensee to comply with a Compliance Order []:
The licensee shall:

a) Acquire equipment that can safely and accurately weigh the identified resident and have that equipment readily available in the building at all times.
b) Weigh the identified resident monthly as per the requirement in the legislation, or, in cases where that is not possible, document the reason the weight could not be obtained within the resident's plan of care.

Grounds
The licensee has failed to ensure the home had a weight monitoring system to measure and record a weight on admission and monthly thereafter for a resident.

Rationale and Summary

A resident was residing in the facility for over three years, and since their admission, only one weight was measured and recorded for the resident.

A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) indicated the reason the resident was not being weighed was the facility did not have an appropriate scale for the resident.

Failure of the home to measure and record the resident's weight put the resident at risk of not having their weight changes monitored for medical and care concerns. At the time of the inspection the resident's weight remained unknown.

Sources: a residents progress notes and weights tab; Interviews with staff; Weights policy.

[741126]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #007 Police notification

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Conduct an audit of complaints received since December 11, 2023 to ensure police are immediately contacted for those complaints where a criminal offence may have been committed. The audit must include a record of the complaints, review of interviews/statements provided and decision notes related to whether a criminal offence may have been committed. If police had not been contacted when a criminal offense may have been committed, document the corrective actions taken. Record the date of the audit, the name and designation of the person conducting the audit, and any follow up actions completed.
b) Ensure all RNs, and managers are provided education in relation to the reporting requirements of a criminal offence. This training should include education on what may constitute a criminal offence. A record of this training must be kept in the home and include the date and time training was provided, attendees and outline of the course content.

Grounds
The licensee failed to ensure that the appropriate police service was immediately notified of the alleged abuse of two residents by a staff member.

Rationale and Summary
a) The police were not notified of an allegation of abuse from a staff member to a resident.

The police were not given the opportunity to investigate and determine if the staff member committed a criminal offence on the date of the allegation as they were not notified of the allegation of abuse.

b) The police were not notified of a second allegation of abuse from a staff member to a resident until the next day.

When the home did not report the alleged abuse of a resident by a staff member to the appropriate police service it posed a high risk to residents. The incident was not investigated by police and the alleged abuser continued to work in the home for more than two months providing care to residents.

Sources: review of resident's clinical records, CI 3051-000004-24, interviews with residents, OPP Detective Sergeant and staff.

[155]

This order must be complied with by July 26, 2024

COMPLIANCE ORDER CO #008 Social work and social services work

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 68
Social work and social services work
s. 68. Every licensee of a long-term care home shall ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents' needs.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Develop a written description of the social work and social services work provided in the home.
b) Develop a written process or procedure for referring to a social worker if the home does not have a social worker. This process should include, but not be limited to, an algorithm or framework for when a staff member would refer to a social worker.
c) Educate all registered staff on the process and framework. A record of this training must be kept in the home and include the date and time training was provided, attendees and outline of the course content.

Grounds
The licensee has failed to ensure that there was a written description of the social work and social services work provided in the home and that the work meets the residents' needs.

Rationale and Summary
The long-term care home did not have a written description of the social work and social services work provided in the home. The long-term care home did not have a social worker, a social worker policy or a procedure for referring to a social worker outside the facility.

A resident expressed having depressive thoughts and feelings because of a change in their lifestyle. They felt they were a burden to the home.

The resident indicated the home did not have a social worker, however, the Chaplain had spoken to them. A Personal Support Worker stated the resident had been upset and would benefit from someone to talk to. A Registered Practical Nurse (RPN) indicated they were unsure of the process to access a social worker, other than informing the Charge Nurse or the Resident Services Coordinator.

The Director of Care indicated that for a resident to receive social work services, the resident would have to make the request themselves and the long-term care home would then look into how to provide this service. They indicated a social worker referral had not been initiated for the above mentioned resident. The Director of Therapeutic Recreation indicated that in the past, one resident had requested social work services, and they explained to them the process to access a social worker. The resident declined this service due to financial barriers.

At the time of the inspection the resident continued to express feelings of sadness, frustration and loneliness and they had not been provided with social work services. Two other residents had not been offered or provided with social work services after reporting abuse.

Sources: resident's progress notes, Suicide Assessment, emails with DOC; Interviews with resident and staff.

[741126]

This order must be complied with by September 6, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.