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

Public Report

Report Issue Date: January 7, 2025

Inspection Number: 2024-1582-0005

Inspection Type:
Critical Incident

Licensee: Corporation of the County of Simcoe

Long Term Care Home and City: Simcoe Manor Home for the Aged, Beeton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 2, 3, 6 and 7, 2025

The following intake(s) were inspected:

- Intake: #00133677- Allegation of Neglect by Staff.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continent Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The Licensee failed to ensure that a resident's individualized plan of care to promote bladder continence was implemented. As a result, their preference was not met and it impacted their dignity.

Sources: Interviews with resident #001, PSW 103 and #104, Critical Incident Report, The Home's Investigation Notes and Resident #001's EHR

WRITTEN NOTIFICATION: Continent Care Product

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The Licensee failed to ensure that a resident's continence care products was changed to remain clean, dry, and comfortable. When continence care was not provided during night shift, the resident was left uncomfortable and was upset.

Sources: Interviews with resident #001, PSW 103 and #104, Critical Incident Report and Resident #001's EHR

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