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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Public Report

Report Issue Date: July 3, 2025

Inspection Number: 2025-1582-0002

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): June 25 – 27, 30, 2025, and July 2, 3, 2025

The following intake(s) were inspected:
-Intake: #00144765, CI #573-000008-25 related to ARI-Coronavirus Outbreak
-Intake: #00145579, CI #573-000010-25 related to Witnessed fall of a resident
-Intake: #00146677, CI #573-000011-25 related to Unwitnessed fall of a resident
-Intake: #00147423, CI #573-000013-25 related to Unwitnessed fall of a resident
-Intake: #00147544, CI #573-000014-25 related to Alleged neglect of a resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's plan of care gave clear direction to registered staff for monitoring medical condition and administration of medication.

The resident had a medical condition that required nursing intervention and prescribed medications including a pro re nata (PRN) medication. In the absence of clear parameters in their plan of care, the PRN medication was not administered as frequently as required.

Sources: review of electronic medical record (eMAR), progress notes, multidisciplinary care conference notes, physician's orders and interview with staff

WRITTEN NOTIFICATION: General Requirements

NC #002 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 failed to ensure that when a resident's medical condition changed the

registered staff reassessed the resident's condition and completed accurate documentation and communication to the care team.

The resident had an acute change in condition. A medication was administered however, the administration was not documented nor a follow up assessment completed. There were no further documented assessments until the evening. This may have contributed to a delay in medical intervention.

Sources: review of resident's electronic eMAR, progress notes, physician orders, pain assessments and interview with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

A) The licensee has failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, and the use of equipment, supplies, devices and assistive aids for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, includes the use of devices and provides strategies to monitor residents, and must be complied with.

A resident's care plan stated that they were to have a fall prevention intervention in place. The resident was observed without this intervention in place.

Source: observation, falls management program policy, care plan, interview with staff

B) The licensee has failed to ensure that the falls prevention and management program provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, includes the use of devices and provides strategies to monitor residents, and must be complied with.

The resident had several fall incidents and required to have falls prevention interventions however, staff did not explore other falls prevention strategies when current interventions were ineffective.

Source: Care plan, falls risk assessment, fall huddle, progress note, falls management program policy, interview with staff

C) The licensee has failed to ensure that the falls prevention and management program provided for the use of equipment, supplies, devices and assistive aids for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, includes the use of devices and provides strategies to monitor residents, and must be complied with.

A resident's care plan stated that they were to have a fall prevention intervention in place. When the resident had a fall, this intervention was not in place.

Source: Falls management program policy, care plan, progress note, callpoint detailed activity report, interview with staff

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

A) In accordance with Additional Requirement 9.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that additional precautions were followed, specifically section (f) additional PPE requirements including appropriate selection application, removal and disposal.

A staff did not wear a required personal protective equipment (PPE) when they were in a room with a resident, who was on specific precautions.

Sources: Observations, signage outside resident room door, interview with staff

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that a incident that resulted in a significant change in a resident's health condition was reported to the Director in a timely manner.

Source: After-hour report, progress note, interview with staff