Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 13, 2014	2014_312503_0001	T-615-13	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26, Midhurst, ON, L0L-1X0

Long-Term Care Home/Foyer de soins de longue durée

SIMCOE MANOR HOME FOR THE AGED
1110 Highway 26, Midhurst, ON, L0L-1X0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LAURA BROWN-HUESKEN (503)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 9-10, 2014

During the course of the inspection, the inspector(s) spoke with Quality and Development Nurse, Registered Nursing staff, Personal Support Workers and Resident.

During the course of the inspection, the inspector(s) reviewed clinical records, reviewed policies related the home's falls prevention program and observed the provision of resident care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that when a resident has fallen a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home's Fall Prevention Policy, NPC E-25 effective date September 2010, directs nursing staff to complete the home’s Post Falls Assessment whenever a resident has fallen or is discovered on the ground. The home's Quality and Development Nurse indicated in an interview that the home's clinically appropriate assessment instrument that is specifically designed for falls is the Post Fall Assessment in Point Click Care (PCC).
Resident 001 had four documented falls in an identified time period of two months. Following this time period, on an identified date, nursing progress notes indicate that resident 001 was found on the floor of the resident's room, the fifth fall. Progress notes further indicate that a physical assessment of the resident was completed at the time of the fall. In 12 days following this fall, resident 001 had three additional falls resulting in an injury and a significant change in status. Review of clinical records and an interview with the home’s Quality and Development Nurse confirm there was no Post Fall Assessment completed for the fifth fall. [s. 49. (2)]

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 13th day of January, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
L. Brown-Huesken