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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Oct 6, 2014	2014_168202_0020	T-092-14	Resident Quality Inspection

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
5988 – 8th Line, Beeton, ON, L0G-1A0

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

VALERIE JOHNSTON (202), ARIEL JONES (566), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589), SOFIA DASILVA (567)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 23, 24, 25, 26, 29, 30, October 01, 02 and 03, 2014.

During the course of this inspection the following complaint inspection was completed, T-646-13 and the following critical incident inspections were completed, T-1113-14 and T-208-14.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), supervisor of programs and support services (SPSS), registered dietitian (RD), supervisor of food services, nurse manager (NM), registered nursing staff, personal support workers, housekeeping staff, dietary aides, president of Residents' Council, residents, families.

During the course of the inspection, the inspector(s) observed the provision of care to residents, conducted a tour of the home, observed lunch meal service, reviewed clinical records,reviewed the home's policies related to infection prevention and control, fall prevention, responsive behaviours, weight changes, reviewed Residents' Council meeting minutes from April-September 2014.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs change.

A review of resident #08's written plan of care for an identified time period, directed staff to provide thin fluids; elevate HOB at least 70 degrees while eating and to feed slowly.

Review of the Speech Language Pathologist assessment notes, for an identified date, confirmed that the resident had difficulty with swallowing thin fluids and the resident should be on nectar thick liquids by sip.

Interview with the RD confirmed that the care plan had not been updated to reflect this change. [s. 6. (10) (b)]

2. A review of the care plan for resident #08 indicated a recent acute illness with hospital stay and bedfast status due to a contracture.

Interview with PSWs and registered staff revealed that the resident is no longer on bedfast and that staff provide assistance to get the resident into the Geri-chair on a daily basis.

The resident's plan of care was not updated when care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident’s health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of 10 per cent of body weight, or more, over 6 months are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

A review of resident #08's clinical records confirmed that resident #08 lost 17.6 per cent or 9.8 kg of body weight over an identified period of time.

Interview with the RD confirmed that the resident lost a significant amount of weight in an identified period of time. The RD confirmed that the resident was not assessed for significant weight loss as he/she was waiting for the resident to be reweighed to verify the accuracy of the recorded weights in the resident's clinical records.

Interview with the RD and the DOC confirmed that the resident should have been assessed for significant weight loss despite any concerns over the accuracy of the recorded weight, as visually, staff confirmed that the resident had lost significant weight over the last several months as a result of a decline in his/her health condition. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 6th day of October, 2014

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