Ontario

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 31, 2015	2015_297558_0004	T-1733-15	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

BARBARA PARISOTTO (558), ANN HENDERSON (559), MATTHEW CHIU (565)

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): March 16, 17,18,19, 20, 23, 24, 26, 27, 2015.

The following critical incidents were completed concurrently with the RQI. T-1395-14, T-1866-15 and T-2031-15.

During the course of the inspection, the inspector(s) spoke with the administrator, director of resident care (DRC), quality and development coordinator, program and support services supervisor (PSS), food services supervisor, physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support worker (PSW), dietary aide, cook, activation staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

An interview with resident #5 revealed the resident prefers to sleep in during the mornings.
A review of a resident assessment protocol (RAP) completed on a specified date, indicated the resident does not like to wake up early.
Staff interviews revealed the resident does not like to be woken if sleeping and typically wakes up between 9:30-9:45 a.m.
A review of the plan of care stated resident #5 prefers to get up at 7:00-8:00 a.m.

Staff interviews confirmed the care set out in the plan of care does not reflect the preferences of resident #5. [s. 6. (2)]

2. On an identified date, the inspector observed resident #8 sitting in a wheelchair in a tilt position. A review of the plan of care did not indicate the wheelchair should be tilted.

An interview with the PT revealed an assessment of the resident requiring a tilt wheelchair would be conducted by an occupational therapist.
An interview with the registered staff revealed an assessment was not completed for

resident #8 regarding the use of a tilt wheelchair and that the nursing staff decided to tilt the wheelchair for positioning and comfort of the resident.

The registered staff confirmed that the plan of care was not based on an assessment of resident #8 and the resident's need for proper positioning when sitting in the wheelchair. [s. 6. (2)]

3. 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 the plan of care for resident #12 identified the resident requires extensive assistance for dressing. The minimum data set (MDS) completed on a specified date, identified the resident as requiring total care and two person assist for dressing. Staff interviews revealed resident #12 requires one person total assist for dressing.

An interview with a registered staff member confirmed the plan of care had not been revised to reflect the changes in the resident's care needs. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On two identified dates, a towel bar was observed to be loosely connected to the wall in resident #1's washroom. A review of the maintenance book located on the unit identified the loose towel bar had not been recorded.
An interview with a registered staff member confirmed he/she was unaware of the loose towel bar and that he/she would record it in the maintenance book.

The following day, the towel bar was observed secure to the wall for resident #1. [s. 15. (2) (c)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm has occurred, immediately report the suspicion and the information upon which it is based to the Director.

An identified critical incident related to alleged resident to resident abuse involving resident #7 was submitted to the Director on an identified date. A record review revealed the incident between the residents occurred three days earlier. [s. 24. (1)]

2. An identified critical incident related to alleged resident to resident abuse involving resident #2 was submitted to the Director on an identified date. A record review revealed the incident between the residents occurred five days earlier.

Interviews with the RN who submitted the critical incident and the DRC confirmed the incidents were not reported immediately. [s. 24. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in carrying out the satisfaction survey.

An interview with the Residents' Council president revealed the Council did not review how the 2014 satisfaction survey was to be carried out.

An interview with the PSS confirmed the advice of the Residents' Council was not sought in carrying out of the 2014 satisfaction survey. [s. 85. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed, of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Record review revealed resident #32 fell on an identified date. The resident was sent to the hospital and diagnosed with a fracture the next day.
Record review of an identified critical incident indicated the report was submitted three days after the fracture was confirmed.

An interview with an identified registered staff confirmed the above mentioned incident was reported to the Director three business days after the occurrence of the incident. [s. 107. (3) 4.]

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Issued on this 15th day of April, 2015

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

Original report signed by the inspector.