Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jan 24, 2017	2016_251512_0013	027174-16	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

TILDA HUI (512), JENNIFER BROWN (647), SHIHANA RUMZI (604)

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 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 22, 23, 26, 27, 28 & 29, 2016.

The following critical incidents were inspected concurrently with this inspection: 002298-15, 009527-16 & 033405-15 related to falls, 023938-15 related to abuse, 020102-16, 023142-16, 024548-16, & 024959-16 related to responsive behavior, and 026931-16 related to resident safety.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Manager (NM), Environmental Services Supervisor (ESS), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide (DA), Residents, Family Members, Power of Attorney (POA), and Substitute Decision Makers (SDM).

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

5 WN(s)
4 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The home submitted an identified CI Report on an identified date to the Ministry of Health and Long Term Care (MOHLTC), indicating that there had been an elopement where resident #009 had exited the home.

A review of resident #009's clinical records revealed that the resident had been identified on the admission care plan dated a day before the incident with the behavior of wandering/elopement and that it had occurred within the previous six months prior to admission.

A review of the progress notes for resident #009, indicated that on the day of admission, the home had been informed that the resident had previously walked out of his/her

previous location.

An interview with RPN #108 who had worked the day of the incident reported that he/she had been concerned when a staff member informed him/her that resident #009 had gone downstairs to the main entrance. The RPN further indicated that he/she was aware that resident #009 had past history of elopement and required to be monitored.

An interview with Dietary Aide #119 indicated that on the day of the incident, a person approached the Dietary Aide in the front lobby and said that the person was a visitor and had forgotten the door code. Dietary Aide #119 further indicated that he/she had checked for a wander bracelet on the person and did not find one, and was not aware that the person was a resident, and therefore opened the door leading to the outside of the home for the person.

An interview with Nurse Manager #103 confirmed that the risk for wandering/elopement had been documented on resident #009’s plan of care as part of the admission documentation for staff to be aware of the potential risk. [s. 6. (4) (a)]

2. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted an identified CI report on an identified date, indicated resident #016 had experienced a fall and sustained a fracture.

A review of resident #016’s written plan of care dated 15 weeks after the incident, indicated an intervention that resident #016 was to be wearing a protective device. Review of the Post Fall Assessment with an identified date, recommended a safety program to protect the resident from injury from falls.

Observations conducted for resident #016 on two identified dates during the inspection period, revealed resident #016 was not wearing the protective device.

Interview with PSW #117 indicated she/he was unaware if resident #016 had the protective device on and was unaware resident was to have them on.

An interview with RN #118 confirmed Post Fall Assessment dated a day before the first observation recommended resident #016 to be on the safety program as resident has had multiple falls in the past and the safety program would help to protect him/her from

injury. RN #118 indicated protective devices are available in the home’s storage area for resident needs. RN #118 confirmed that the resident was not wearing the protective device as recommended on the post fall assessment during one observation of the resident conducted with the Inspector.

Interview with the DOC indicated that protective devices are available in the home’s storage area for resident needs and unsure as to why resident #016 did not have one on. The DOC indicated the protective device will be given to the resident as soon as possible. [s. 6. (7)]

3. The licensee has failed to ensure that the following are documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care.

The home submitted an identified CI Report on an identified date indicating there had been an elopement where resident #009 had exited the home.

A review of resident #009’s clinical records revealed that the resident had been identified on the admission care plan dated a day before the incident, with the behavior of wandering/elopement and that it had occurred within the previous six months prior to admission.

A review of the resident’s progress notes indicated on the day of admission, the home had been informed that the resident had previously walked out of his/her previous location.

An interview with RPN #108 who had worked the day of the incident reported that he/she had been concerned when a staff member informed him/her that resident #009 had gone downstairs to the main entrance. The RPN further indicated that he/she was aware that resident #009 had past history of elopement and required to be monitored.

A review of the written care plan dated a day after admission, indicated the resident’s whereabouts was to be checked every 30 minutes on the safety checklist. A review of the safety checklist indicated that resident’s whereabouts was to be checked every 15 minutes on the safety checklist. A review of the safety checklist for resident #009 from the time of admission to 17 days after admission, revealed that resident’s whereabouts had not been checked for 15 time slots. On two separate days during the above mentioned time period, the resident's whereabouts had not been checked for a period of

five and a half hours and eight hours respectively.

Interviews with RPN's #108, #116 and PSW #109 indicated that resident had been on every 15 minute checks to ensure he/she was monitored for his/her whereabouts, but was not conducted all the time. The direct care staff mentioned above also indicated that the expectation was for resident's whereabouts to be documented on the safety checklist.

Interview with the Director of Care (DOC) indicated the purpose of the safety checklist is to ensure all residents who were at risk for elopement were monitored for their whereabouts and the expectation was for all scheduled times to be signed by staff to ensure the resident was safe. The DOC further indicated as a result of the above mentioned gaps in documentation, care had not been provided to resident #009 as specified in the plan of care. [s. 6. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, that care set out in the plan of care are provided as specified in the plan, and that the provision of care, outcomes and effectiveness of the plan of care are to be documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and   O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspection on resident #001 was initiated in stage two for nutrition and hydration due to weight loss identified through census review. Review of resident #001’s weights indicated resident had lost 3.5 kg of his/her weight in an identified one month's time.

Interview with RN #112 indicated resident #001 had low meal intake at the beginning of the identified month, and had further declined in meal intake thereafter. The RN indicated the home’s expectation was when a resident’s intake was lower than 50% consecutively for three days, a dietary referral was to be carried out. The RN further indicated there was no dietary referral carried out following three consecutive days of low meal intake of resident #001. The RN stated a dietary referral to address the resident's weight loss and low meal intake was not sent until one month after the weight loss was identified.

Home’s policy titled “Nutrition, Hydration, and Dining” “Referral to Dietitian”, policy number NPC H-45, supersedes date November 2014. Under the Procedure section, the policy directs RN/RPN to complete the electronic Dietitian Referral Form and forward it to the Registered Dietitian for a Resident experiencing any of the following. Procedure #2: Unplanned inadequate food intake/appetite; experienced for three or more days, food consistently less than 50% consumed at and between meals.

An interview with the home’s Registered Dietitian (RD) indicated he/she did not receive a dietary referral for resident #001’s low intake in the identified month. The RD reviewed resident #001’s meal intake and indicated a dietary referral should have been made the first week of the identified month as that was when he/she can see decreased meal intake for resident #001. The RD further stated the home’s expectation was when a resident’s intake was lower than 50% consecutively for three days, a dietary referral was to be carried out. The RD confirmed a referral was not carried out for resident #001 as per home’s policy.

An interview with the Director of Care (DOC) confirmed a dietary referral should have been carried out when resident #001’s intake was noted to have decreased and staff did not follow home’s policy related to sending a dietary referral. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents are protected from abuse by the licensee or staff in the home.

The home submitted an identified CI report on an identified date of a suspected staff to resident incident of abuse at resident #010 by PSW #125.

Review of the CI report revealed that the incident was reported by PSW's #126 and #127. The PSWs heard the resident and observed the staff member abusing the resident. Resident #010's written plan of care with an identified date was reviewed to note the resident's cognitive status and the level of care and assistance required for activities of daily living.

Record review and interview with Nurse Manager #103 indicated that an investigation on the alleged abuse had been conducted by the home, and PSW #125 was disciplined for abuse.

Review of the homes' investigation notes revealed the resident had been initially upset about the incident although had no adverse effect. Resident #010 did not recall incident

at this time.

Interview with Nurse Manager #103 confirmed that resident #010 had not been protected from verbal and physical abuse by PSW #125 at the home. [s. 19. (1)]

2. The home submitted an identified CI report with an identified date of a suspected abuse by staff to resident #026.

Review of the CI report and the home's investigation notes revealed on the date of the incident at the dinner meal service, resident #026 made a complaint to RPN #135 that PSW #128 abused him/her while providing care. The resident indicated that similar situations had occurred before with this particular PSW, and this time the resident reported it as he/she could not take it anymore. The home initiated investigation immediately. The PSW was disciplined at the conclusion of the investigation and the resident was comforted and reassured.

The Inspector interviewed the resident who recounted details of the incident. The resident indicated he/she recognized the PSW involved but did not know the PSW's name. The resident was able to identify the involved PSW to the home's nursing management during the investigation. The resident stated that he/she did not report previous similar situations as he/she did not want to get anyone in trouble. The resident stated at the latest incident, he/she decided to report to the registered nursing staff. The resident said the PSW was always rushing and rough when providing care and the PSW was the only staff that work that way.

Interview with PSW #128 stated that the PSW had been told that he/she was rushing when worked and was told to slow down. The PSW indicated that he/she had no intention to abuse the residents, however admit that he/she was sometimes rushed to finish his/her assigned tasks. The PSW recalled during the incident, he/she was dressing the resident.

Interview with RPN #135 confirmed the PSW appeared rushed when he/she performed tasks and had reminded the PSW to slow down. The RPN indicated there had been no previous similar complaints from residents against PSW #128.

Interview with RPN #135 and the DOC confirmed resident #026 was not protected from abuse by staff in the home. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are protected from physical and verbal abuse by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have receive retraining annually relating to the following: The Residents' Bill of Rights, The home's policy to promote zero tolerance of abuse and neglect of residents, The duty to make mandatory reports under section 24, and The whistle-blowing protections.

Review of the training record in 2015 revealed 91 per cent of all staff at the home received the training related to abuse and neglect of residents, the Residents' Bill of Rights, Mandatory Reporting and whistle-blowing protections.

Interview with the DOC and the Nurse Manager confirmed that nine per cent of the home's staff were not provided with the above mentioned training in 2015. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff have receive retraining annually relating to the following: The Residents' Bill of Rights, The home's policy to promote zero tolerance of abuse and neglect of residents, The duty to make mandatory reports under section 24, and The whistle-blowing protections, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee’s written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

Review of the home’s policy titled Resident Abuse, policy number ADM F-10 effective date December 1, 2014, revealed the policy did not include procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

Interview with the DOC and the NM confirmed that the home's written policy on abuse did not include the above mentioned clause. The DOC indicated the policy was developed by the corporate office and he/she will bring it to their attention. [s. 96. (b)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including: i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and ii. situations that may lead to abuse and neglect and how to avoid such situations

Review of the home’s policy titled Resident Abuse, policy number ADM F-10 effective date December 1, 2014, revealed the policy did not include the identification of the training and retraining requirements for all staff including: i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and ii. situations that may lead to abuse and neglect and how to avoid such situations.

Interview with the DOC and the NM confirmed that the home's written policy on abuse did not include the above mentioned clause. The DOC indicated the policy was developed by the corporate office and he/she will bring it to their attention. [s. 96. (e)]

Issued on this 29th day of January, 2017

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

Original report signed by the inspector.