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

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
Mar 1, 2017	2016_251512_0015	012494-16	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 21, 22, 26, 27, 28, and 29, 2016.

Intake #012494-16 related to plan of care was inspected at this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Manager (NM), Registered Nurse (RN) Registered Practical Nurses (RPNs), Personal Support Workers (PSWs).

During the course of the inspection, the inspector conducted observation in home and residents' areas, and review of the home's documentation survey records, bathing schedule, medication administration records, staff schedules, relevant policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan.

This inspection was initiated related to a complaint submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding plan of care concerns of resident #001.

Record review revealed that resident #001 was admitted on an identified date to the home for a respite stay of two weeks.

Review of the resident's progress notes and medication administration record indicated the resident started feeling unwell five days after admission and told nursing staff that. Sometime during the day, the resident was noted to have a change in his/her physical status and was given a specified medication as ordered by medical directives implemented on admission. The resident was put on a preventive intervention requested by RN #107 as per the home's practice. The resident's physical status appeared back to normal later that day. Record review further indicated that on the sixth day after admission, the resident had additional physical complaints. RPN #101 administered the specified medication to the resident and implemented specified interventions for his/her altered physical condition. The resident was assessed by the attending physician who made rounds on the same day, and ordered a second specified medication for the

resident. The resident was administered the first dose of this medication six and a half hours after it was ordered. The resident experienced further changes in his/her physical condition and was transferred to the hospital the next day.

There was no documentation in the progress notes to indicate that the resident's family was informed when the resident was put on preventive intervention and when the resident's condition changed.

The resident was discharged prior to this inspection and was not available for interview. The spouse who was the complainant was not available for interview.

Interview with RN #107 indicated that he/she did not inform the family when the resident was put on the preventive intervention. RN #107 stated he/she thought that the resident's issue would resolve soon and it would not be necessary to inform the family. Interview with RPN #101 indicated that the family was not informed when the resident presented with signs and symptoms of a change in health condition.

Interview with the DOC confirmed that the family of resident #001 had not been provided with the opportunity to participate fully in the development and implementation of the resident's care plan. [s. 24. (5)]

2. The licensee has failed to ensure that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change.

This inspection was initiated related to a complaint submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding plan of care concerns of resident #001.

Record review revealed that resident #001 was admitted on an identified date to the home for a respite stay of two weeks.

Review of the resident's progress notes and medication administration record indicated the resident started feeling unwell five days after admission and told nursing staff that. Sometime during the day, the resident was noted to have a change in his/her physical status and was given a specified medication as ordered by medical directives implemented on admission. The resident was put on a preventive intervention requested by RN #107 as per the home's practice. The resident's physical status appeared back to normal later that day. Record review further indicated that on the sixth day after admission, the resident had additional physical complaints. RPN #101 administered the

specified medication to the resident and implemented specified interventions for his/her altered physical condition. The resident was assessed by the attending physician who made rounds on the same day, and ordered a second specified medication for the resident. The resident was administered the first dose of this medication six and a half hours after it was ordered. The resident experienced further changes in his/her physical condition and was transferred to the hospital the next day.

Review of resident #001's 24-hour admission care plan did not reveal revisions on the changing condition of the resident and the interventions implemented in managing the change.

The resident was discharged prior to this inspection and was not available for interview. The spouse who was the complainant was not available for interview.

Interview with the DOC confirmed that the resident's 24-hour care plan was not revised when the resident's care needs changed. [s. 24. (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 the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan, and that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

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Issued on this 1st day of March, 2017

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

Original report signed by the inspector.