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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2018	2017_414110_0014	026634-17	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

DIANE BROWN (110), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 28, 29, 30, 2017. December 1, 4, 5, 6, 7, 8, 11, 12, 13, 15, 18, 19, 20, 21, 22, 2017.

The following critical incident was inspected concurrently with this inspection::
Log #022226-17 related to a medication incident
The following complaints were inspected concurrently with this inspection::
Log #012246-17 allegation of resident to resident abuse
Log #012667-17allegation of resident to resident abuse
Log #019436-17 allegation of resident to resident abuse

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Nurse Manager (NM), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide (DA), Administrative clerk, Residents, Family Members, Power of Attorney (POA), and Substitute Decision Makers (SDM), Supervisor of Program and Support Services, Activation Aides, Quality and Development Home Coordinator (QDHC)

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

11 WN(s)
7 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. (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).

Findings/Faits saillants :

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

During the RQI, resident #007 was triggered related to altered skin integrity.

Review of the resident’s written plan of care, indicated that as per the wound care specialist, resident #007 was only to be up in his/ her wheelchair for an hour at meal times to allow his/ her altered area of skin integrity to heal.

An observation of resident #007 was conducted during this inspection and the resident was identified, in the TV room of an identified home area, sitting in his/ her wheelchair for an identified period of time after lunch service.

Interviews with PSW #112 and RPN #113, confirmed resident #007 had an area of altered skin integrity and he/ she would get up for all meals and go back to bed after meals to alleviate the pressure on the identified area. The PSW and RPN acknowledged the above mentioned observation and further confirmed that resident #007 had not been provided the care set out in his/ her plan of care.

Interview with the DOC acknowledged the above mentioned information and that resident #007’s plan of care had not been followed. [s. 6. (7)]

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 written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules had been complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the tour of the home on November 28, 2017, at 1045 hrs, in the Innisfil unit, the balcony door was observed to be unlocked. The inspector was able to open the door and access the balcony from the activity room in the Innisfil unit. The balcony door had a secure keypad system, and a green light was observed at the time of the tour. There were no residents observed in the activity room and in the balcony. The inspector interviewed HKA #105 who was nearby, and confirmed that the balcony door was supposed to be locked with the keypad code.

Interview with Administrator #106 who was covering for the Administrator of the home, confirmed that the balcony door was supposed to be kept closed and locked when not supervised by the staff. [s. 9. (1) 2.] (653)

2. The licensee has failed to ensure that the following rules had been complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the tour of the home on November 28, 2017, at 1024 hrs, in the Essa unit, the door to the dining room servery was observed to be unlocked. The inspector was able to open the door and access the servery from the hallway. On the countertop inside the servery, the following were observed: The coffee machine which also dispenses hot water had the green light on, and sharp items such as scissors and knives were noted. There were no residents observed in the hallway, the servery, and in the dining room.

The inspector interviewed PSW #101 who was nearby, and acknowledged the potential risk of harm that the coffee machine and the sharp items may pose on the residents. PSW #101 and DA #102 confirmed that the door to the servery should be locked.

Interview with Quality and Development Home Coordinator (QDHC) #100 confirmed that the door to the servery should have been locked, and further indicated that the servery should be secured so residents cannot access it, as it is considered a non-residential area. [s. 9. (1) 2.] (653)

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 all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure the responsive behaviour plan of care based on an interdisciplinary assessment of the resident includes any potential behavioural triggers.

The Ministry of Health and Long Term Care received three complaints related to an allegation of resident to resident altercation.

Review of the clinical records revealed that resident #005 had identified responsive behaviours related to his/her diagnosis. A review of progress notes identified a longstanding history of confrontations between residents #005 and #009.

Interviews with 11 staff revealed a long standing pattern of conflict between resident #009 and #005. The interviews further identified that they refer to the kardex or written care plan or a daily assignment sheet for care directions.

Interview with registered staff #123, the home's lead for responsive behaviours revealed the trigger for resident # 005's behaviour.

A review of the kardex, written care plan and daily assignment sheets failed to identify interventions related to the conflict and behavioural trigger of resident #009.

Interviews with registered staff #119 and #120 confirmed that there were no interventions identified in the written plan of care, kardex or daily assignment sheets related to the conflict and behavioural trigger.

Interview with the DOC acknowledged the absence of interventions related to the residents conflict. [s. 26. (3) 5.]

2. The licensee failed to ensure the responsive behaviour plan of care based on an interdisciplinary assessment of the resident includes any potential behavioural triggers.

The Ministry of Health and Long Term Care received three complaints related to an allegation of resident to resident altercation.

A review of resident #009's clinical records identified no cognitive impairment, that the resident was his/her own POA and could become short tempered and angry towards staff and residents.

Record review of progress notes identified a history of confrontations between resident #009 and #005.

Interviews with 11 staff revealed a long standing pattern of conflict between residents #009 and #005. Staff interviews further identified that they refer to the kardex, written care plan or a daily assignment sheet for care directions.

Interview with registered staff #123, the home’s lead for responsive behaviours revealed the trigger for resident #005’s behaviour was resident #009 and vice versa.

Interview with staff #107 new to the unit as of November 1, 2017, identified resident #009 in his/her assignment. Staff #107 revealed he/she had not been provided direction on the potential behavioural triggers for resident #009.

A review of the kardex, written care plan and daily assignment sheets failed to identify interventions related to the conflict with resident #009 and behavioural trigger.

Interviews with registered staff #119 and #120 confirmed that there were no interventions identified in the written plan of care, kardex or daily assignment sheets related to the conflict and behavioural trigger.

Interview with the DOC acknowledged the absence of interventions related to the resident to resident conflict.
[s. 26. (3) 5.] (110)

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 the responsive behaviour plan of care based on an interdisciplinary assessment of the resident includes any potential behavioural triggers, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee failed to ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying and implementing interventions.

The Ministry of Health and Long Term Care received three complaints related to an allegation of resident to resident altercation.

Review of the clinical records revealed that resident #005 had identified responsive behaviours related to his/her diagnosis. A review of progress notes identified a long standing history of resident to resident confrontations.

Interviews with 11 staff revealed a long term pattern of negative interaction between resident #009 and #005.

Interview with the Administrator identified interventions taken in the past to address the negative interaction but confirmed the conflict remained.

It was not until complaints to the home and the Ministry’s inspection that resulted in further assessment of the behaviours that action was taken.

The home failed to take steps taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.[s. 54. (b)] (110)

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to the residents in accordance with the directions for use specified by the prescriber.

The home submitted a CIS to the Director, for a medication incident that altered a resident's health status. The CIS indicated that on an identified date and time, resident #008 received the wrong dose of medication. The medical director advised staff to transfer the resident to the hospital for observation.

Record review revealed the resident received the wrong dose of medication.

Interview with the RN confirmed that RPN #139 had incorrectly administered the medication, called the physician, the SDM, and resident #008 was sent to the hospital immediately. The RPN confirmed the medication error and further indicated that he/she did not administer the drug to the resident as ordered by the physician.

Interview with The DOC confirmed the medication incident had occurred and that resident #008's medication was not administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (653)

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 drugs were administered to the residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction had been reported to the resident's SDM, if any, and the resident's attending physician.

As part of the RQI, all medication incidents and adverse drug reactions from the past quarter that had been analyzed and evaluated in the home's most recent Professional Advisory Committee Meeting, had been reviewed.

Interview with RPN #110 stated that when a medication incident occurred, the registered staff who discovered the error would assess and monitor the resident, notify the physician, family, pharmacy, the charge nurse, and the DOC. The registered staff would also fill out the medication incident report online, and document on the progress notes under medication incidents.

A review of the home's medication incidents from September to November 2017, revealed a medication incident that had occurred involving resident #015. Review of the medication incident final report from September, 2017, indicated that the type of incident was incorrect dose, and the severity/outcome description was "an error occurred that reached the patient but did not cause patient harm". Further review of the document revealed RPN #138 administered resident #015's 1700 hrs medications, and the resident inquired if he/ she got three white pills. The RPN then checked the medication pouch and found there were three identified tablets, however, resident received two. The document indicated that the family and the physician were not notified.

During an interview, the inspector and the DOC reviewed the above mentioned medication incident report. The DOC acknowledged the lack of notification to the appropriate individuals following the medication incident. The DOC further indicated that the home's expectation was for registered staff to notify the physician and the SDM when a medication incident occurred. [s. 135. (1) (b)] (653)

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 every medication incident involving a resident and every adverse drug reaction had been reported to the resident's SDM, if any, and the resident's attending physician, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

During the tour of the home on November 28, 2017, at 1129 hrs, in the shower room of the Adjala unit, the seatbelt of the shower chair was noted to be wet – evidence of recent use, heavily soiled, brown stained, had soap residue, and in poor condition.

Interview with PSW #104 confirmed that the shower chair had been used that morning to shower a resident. Both staff were present during observation, and confirmed that the seatbelt was brown stained, unclean, and had soap residue from previous use. PSW #104 and RPN #103 confirmed that the PSWs were responsible for cleaning and disinfecting the shower chairs including the seatbelts, with virox and cavi wipes after each resident use.

Interview with Quality and Development Home Coordinator (QDHC) #100 acknowledged the above mentioned information and that the staff did not participate in the implementation of the infection prevention and control program. He/ she further indicated that the home's expectation was for the PSWs to clean and disinfect the shower chair including the seat belt after each resident use.[s. 229.(4)] (653)

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 participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: 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 :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 48 (1) 2, Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Review of the home's policy titled "Skin and Wound Management Program" policy #NPC E-30, effective July 2017, indicated under the RN/ RPN's roles and responsibilities to "Contact Physician and communicate recommendations from the Wound Specialist and obtain order. Stage 3 or greater requires a Physician's Order".

During the RQI, resident #002 was triggered related to an area of altered skin integrity.

Review of resident #002's skin and wound care consultation on an identified date, revealed he/she had an area of altered skin integrity in an identified area. The treatment indicated five suggestions.

Review of the eTARs for a relevant two month period failed to indicate the five treatment suggestions.

Interview with Wound Care RPN #115 stated that the home's process in regards to the treatment recommendations by the wound care clinical consultant, was for the registered staff to print a copy of the skin and wound care consultation with treatment suggestions, and place it in the physician's binder for the doctor to review, and order to be implemented accordingly. There was no information obtained from the record reviews and staff interviews, to indicate that the physician had been aware of the skin and wound care consultation with the treatment suggestions. Interviews with the Wound Care RPN and the DOC acknowledged that the home's policy had not been complied with. [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident’s plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident’s bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident’s bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

The licensee failed to ensure that, a comfortable easy chair is provided for every resident in the resident’s bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so.

This IP was triggered during stage 1 of the RQI related to a family interview.

Interview with resident #001’s family revealed when asked if the resident was able to have his/her furniture if she/he wishes, that the home had removed the chair in the resident's room. The family member revealed that she/he has to go elsewhere to sit and visit with his/her mom/dad and is why he/she has been requesting a private room.

Resident #001’s room was observed on December 15 and 20, 2017, and did not include a chair, which was confirmed by staff #134 and #133.

Interview with the Administrator revealed that it was the home’s expectation that all residents have a chair in their room. The Administrator confirmed the absence of a chair in resident #001’s room and readily provided for one. [s. 12. (2) (e)]

WN #10: 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):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident: A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The home informed the Director regarding a medication incident that altered a resident's health status, through the MOHLTC after hours pager on an identified date, two days after the incident occurred when the resident was admitted to the hospital because of the medication incident.

During an interview, the DOC acknowledged the above mentioned medication incident, and confirmed that the home failed to inform the Director no later than one business day after the occurrence of the medication incident, as required.
[s. 107. (3) 5.] (653)

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident’s written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

Every licensee of a long-term care home shall ensure that the resident's written record is kept up to date at all times.

The Ministry of Health and Long Term Care received three complaints related to an allegation of resident to resident altercation.

Review of the clinical records revealed that resident #005 had identified responsive behaviours related to his/her diagnosis. A review of progress notes identified a long standing history of resident to resident confrontations. Interviews with 11 staff revealed a long term pattern of negative interaction between resident #009 and #005.

Interview with the Administrator identified that in the past they and had a social worker involved. Record review of progress notes identified on an identified date that social worker #132 was initially consulted. Further documentation identified that social worker #132 was in the home and spoke with three RPN's.

Record review failed to identify any documentation from social worker #132.

The Administrator confirmed that notes were not available from social worker #132 as required and that attempts to obtain notes had been made but documentation was not available to inspectors.

The resident's written record was not kept up to date at all times. [s. 231. (b)] (110)

Issued on this 28th day of January, 2018

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

Original report signed by the inspector.