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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 9, 2019	2018_760527_0026	022001-17, 008847-18, 018036-18, 018336-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

Long-Term Care Home/Foyer de soins de longue durée

Simcoe Manor Home for the Aged
5988 8th Line, Main Street East P.O. Box 100 Beeton ON L0G 1A0

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

KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 21, 22, 23, 26, 27, 28, 30 and December 3, 2018.

During the Critical Incident System (CIS) Inspection the following inspections were conducted:

Log # 009091-17, related to alleged resident to resident abuse;
Log #019130-17, related to alleged resident to resident abuse;
Log #008847-18, related to alleged staff to resident abuse;
Log #018036-18, related to alleged staff to resident abuse; and
Log #018336-18, related to alleged resident to resident abuse.

This Critical Incident Systems Inspection was conducted concurrently with the Compliant Inspection and findings of non-compliance have been included in the Complaint Inspection Report #2018_760527_0025.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Associate Director of Care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), the Quality & Professional Standards Coordinator and the home's administrative staff.

During the course of this inspection, the inspector toured the home, reviewed the licensee's policies and procedures, reviewed clinical records, interviewed staff and residents/families, and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	Légende 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Registered Practical Nurse (RPN) #118, assessed resident #010 and documented the resident had altered skin integrity.

The clinical record was reviewed and the Physiotherapy (PT) assessment identified the resident required a specific type of transfer and device. The written plan of care also identified the resident required a specific type of transfer and device.

Personal Support Worker (PSW) #116 acknowledged they provided care to resident #010 and had transferred the resident without a second PSW. The PSW acknowledged that they had not checked the plan of care.

RPN #118 said that PSW #116 transferred the resident alone.

The DOC identified the resident was not transferred based on the PT assessment and the plan of care.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #010.

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 10th day of January, 2019

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

Original report signed by the inspector.