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_0025	021986-17, 025620-17, 027492-17, 020878-18	Complaint

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 Complaint inspection.

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

During the Complaint Inspection the following inspections were conducted:

Log # 021986-17 and Log #022001-17, related to alleged abuse;
Log # 025620-17, related to alleged abuse;
Log #027492-17, related to resident charges; and
Log #020878-18 and Log #017812-18, related to alleged abuse.

This Complaint Inspection was also conducted concurrently with Critical Incident Systems (CIS) Inspection (Report #2018_760527_0026) and the findings of non-compliance from the CIS inspection have been included in this Complaint Inspection Report #2018_760527_0025.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), 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, the home's investigative notes, reviewed the home's business records, reviewed clinical records, interviewed staff and residents/families, and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Responsive Behaviours

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

6 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy titled "Zero Tolerance of Abuse and Neglect", directed registered staff to conduct a specific assessment of the resident and document the findings.

A) The home's documentation indicated that resident #001 was abused, which resulted in altered skin integrity.

The clinical record was reviewed and there was no documentation related to the specific assessment.

The Administrator acknowledged that registered staff were expected to complete the specific assessment on any resident where there was alleged physical abuse and document in the skin assessment tool in Point Click Care (PCC) and this was not done for resident #001.

B) There was an allegation of physical abuse by PSW #116 to resident #006.

The clinical record was reviewed and there was no documentation related to the specific assessment staff were to complete.

RPN #118 said that they had completed the specific assessment, but was unable to locate that assessment in the resident's clinical record. The RPN acknowledged that they were expected to comply with their Zero Tolerance of Abuse and Neglect policy and they were also expected to complete the specific assessment in the skin assessment tool in

PCC.

C) Resident #008 was allegedly abused by resident #007, which caused resident #008 to have altered skin integrity.

The clinical record was reviewed and there was no documentation related to the specific assessment that should have been conducted.

The Director of Care (DOC) acknowledged that registered staff were expected to comply with their Zero Tolerance of Abuse and Neglect policy and they were also expected to complete the specific assessment in the skin assessment tool in PCC and this was not done for residents #001, #006 or #008.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

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 policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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 failed to ensure that where a person had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

The licensee's policy titled "Zero Tolerance of Abuse and Neglect", was reviewed and identified the legislative requirements related to s. 24 (1) Mandatory Reporting and that staff must immediately report every alleged, suspected or witnessed incidents of abuse of a resident by anyone to the MOHLTC Director.

A) According to the critical incident report, resident #001 was physically abused. The critical incident report also identified that there was no notification to the Ministry of Health and Long Term Care (MOHLTC) after hours pager and there was no critical incident submitted until the following day after the incident.

RN #112 said that they were not on duty at the time of the incident and it was the following day that they interviewed the resident, notified and submitted the critical incident report to the MOHLTC. The RN acknowledged that they did notify the MOHLTC Director immediately.

The Administrator also acknowledged that the abuse of resident #001 should have been immediately reported to the Director at the MOHLTC.

B) According to critical incident report, resident #008 was physically abused by resident #007. The critical incident report also identified that there was no notification to the MOHLTC after hours pager and there was no critical incident report submitted until a number of days after the incident.

RN #120 said that they were not on duty at the time of the incident and acknowledged that if they were unable to submit the critical incident report, that the MOHLTC Action Line number was in the nursing office and posted throughout the home, so there was no reason why the Director was not notified of an alleged abuse of a resident.

The DOC acknowledged that the abuse of resident #008 should have been immediately reported to the Director at the MOHLTC.

The licensee failed to ensure that where a person had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

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 where a person has reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

A) Resident #001 was physically abused. The resident's substitute decision maker (SDM) was not notified of the physical abuse until the following day.

RN #112 acknowledged that they were not working at the time of the incident, but when they came on duty the next day, they had conducted the interview with the resident and had notified the resident's SDM of the incident. The RN was not aware as to why the resident's SDM was not notified when the incident occurred.

The Administrator acknowledged that the resident's SDM was not notified immediately after the abuse occurred.

B) Resident #008 was physically abused by resident #007. Resident #008's substitute decision maker (SDM) was not notified of the physical abuse until three days later.

The DOC acknowledged that the resident's SDM was not notified immediately after the abuse occurred.

The licensee failed to ensure that resident #001's and #008's SDMs were notified immediately upon the licensee becoming aware of an alleged incident of abuse of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

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's substitute decision-maker, if any, and any other person specified by the resident, were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

According to a critical incident report, resident #001 was physically abused by a specific person.

The licensee's policy titled "Zero Tolerance of Abuse and Neglect", directed staff that they must report to the police if the alleged, suspected or witnessed incident of abuse or neglect constituted a criminal offence under the Criminal Code.

RN #112 said it was the following day, that they were on duty and notified the police of the alleged abuse.

The Administrator acknowledged that the police were not notified immediately after the alleged abuse of resident #001.

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

The Prevention of Abuse and Neglect 2017 annual program evaluation was reviewed and there were no dates identified as it related to when the changes and improvements were implemented.

The licensee's policy titled "Zero Tolerance of Abuse and Neglect", directed the staff to keep a written record of each evaluation, which included the date(s) the changes were implemented.

The Administrator acknowledged that they were expected to identify the date(s) on the annual program evaluation, when the prevention of abuse & neglect changes / improvements were implemented and this was not done.

The licensee failed to ensure that the written record of the 2017 annual program evaluation included the date that the changes and improvements were implemented.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Resident #003's SDM and family had reported concerns to the home related to the resident's care and behaviours of other residents towards resident #003 during 2017 and 2018. The family called the Ministry of Health and Long Term Care Action Line on a specific date in 2017, to report that the resident had been abused several times by other residents and this had been going on for a number of months.

Resident #003's clinical record was reviewed and confirmed the number of complaints related to care and behaviours of other residents towards resident #003.

The home's Complaint Logs were reviewed and there were no complaints by the SDM and/or family initiated, investigated, actions taken, time frames with follow-up responses, the final resolution and responses provided to the complainants noted in the logs related to resident #003.

The DOC acknowledged that based on the legislative requirements, there should have been a formal complaint initiated and investigated, as a result of the SDM and/or family concerns.

The licensee failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

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.