Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: July 18, 2024
Inspection Number: 2024-1582-0002
Inspection Type: Critical Incident (CI)
Licensee: Corporation of the County of Simcoe
Long Term Care Home and City: Simcoe Manor Home for the Aged, Beeton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8-11, 2024

The following intake(s) were inspected:

- Intake: #00114061 and #00119351 - CI #573-000007-24 and #573-000009-24 - Related to falls prevention and management

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REASSEMENT, REVISION

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that a resident's plan of care was revised because care set out in the plan of care in relation to falls had not been effective, different approaches were considered in the revision of the plan of care.

Rationale and Summary

A resident was cognitively impaired and had a history of falls.

The resident sustained an unwitnessed fall, resulting in injuries.

The resident's care plan was not updated to include the strategies staff suggested. A staff member also indicated the suggested strategies would not be effective.

When the resident's care plan was not revised to include different approaches regarding falling, they were at risk of future falls.
Sources: Interviews with staff, the resident's physical and electronic medical documentation. [#000869]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING

TECHNIQUES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

Rationale and Summary

The resident required two staff assistance with transfers, including from their mobility device.

The resident sustained a fall when they were assisted by one staff member during a transfer. As a result, they sustained injuries.

The Director of Care (DOC) and staff stated that the resident should have been transferred with the assistance of two staff.

Sources: Interviews with the resident and staff, the resident's physical and electronic medical documentation. [#753]