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

Central West District
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Original Public Report

Report Issue Date: November 8, 2024	
Inspection Number: 2024-1582-0003	
Inspection Type: Critical Incident Proactive Compliance Inspection	
Licensee: Corporation of the County of Simcoe	
Long Term Care Home and City: Simcoe Manor Home for the Aged, Beeton	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22,-25, 28,-30, 2024
The inspection occurred offsite on the following date(s): October 31, 2024 and November 4, 5, 2024
The following intake(s) were inspected:

- Intake: #00129370 -Proactive compliance inspection
- Intake: #00130801 - allegation of neglect from staff to resident

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

Food, Nutrition and Hydration
Medication Management

Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Action

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (3)
Resident and Family/Caregiver Experience Survey
s. 43 (3) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly.

The home failed to make every reasonable effort to act on the results of the 2023 resident and family survey when an area of improvement identified was not acted upon.

Rationale and summary

The home's 2023 resident survey was conducted. and the results identified meal temperature as a critical area for improvement.

No documentation related to food temperature concerns, or any actions taken were found when the home's past year of quality and resident safety committee meetings and QIP Narrative (quality improvement plan) posted on the home's website, dated February 2024 were reviewed.

The Director of Resident Care (DRC) confirmed that the 2023 Resident satisfaction survey identified a critical area for improvement related to food temperatures and was unaware of any action taken to respond to the survey result.

During the inspection residents stated food in the home was cold at times when served to them.

When the home did not take action related to an area of the resident survey identified there was risk to residents for food borne illness and palatable food being served.

Sources:

Interviews with staff and residents, 2023 resident satisfaction survey, 2023 family satisfaction survey, quality and resident safety committee meeting minutes, QIP Narrative from home's website.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is

equipped with a resident-staff communication and response system that,
(b) is on at all times;

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that, is on at all times.

Rationale and summary

The nurse call bell system in a resident room was found not to be working. Neither of the bedside call bells that had been provided for the residents use functioned.

As such, the communication and response system was not functioning at all times, posed a risk for residents' safety and impact to residents' care delivery.

Sources:

Observations of resident room, Callbell detailed activity report

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who

participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) The licensee failed to ensure the written evaluation for the skin and wound program for 2023 contained all required elements.

Rationale and summary

The 2023 program evaluation for the skin and wound program did not identified the actual date of the evaluation, the names of persons who participated in the evaluation or the dates of the implementation of the identified changes to their skin and wound program.

The evaluation was reviewed with the DRC. They acknowledged items were not completed.

Sources: 2023 and 2024 required program evaluation - skin and wound, Steering committee meeting minutes - April 2024, interview with DRC

B) The licensee failed to ensure the written evaluation for the pain management program for 2023 contained all required elements.

Rationale and Summary:

The 2023 program evaluation for the pain management program did not identified the actual date of the evaluation, the names of persons who participated in the evaluation or the dates of the implementation of the identified changes to their skin and wound program.

The evaluation was reviewed with the Director of Resident Care (DRC). They acknowledged items were not completed.

Sources:

2023 and 2024 required program evaluation - pain management, Steering committee meeting minutes - April 2024, interview with DRC

WRITTEN NOTIFICATION: Nursing and personal support services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that there was a written record of the home's staffing plan that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and summary

The home was to have completed an annual evaluation of their staffing plan for nursing and personal support services. The home was unable to provide a written record of this plan.

The Director of Resident Care (DRC) stated that the home did not have a written record relating to the home's staffing plan that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

When the home did not evaluate the effectiveness of their nursing and personal support services staffing plan, there was a missed opportunity for input from others that may have offered suggestions for improvement.

Sources:

DRC interview

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 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 positioning techiques for a resident, resulting in a resident fall.

Rationale and summary

A resident had limited mobility. They required staff assistance for positioning.

Their plan of care directed that two staff should provide with bed mobility.

Staff did not provide bed mobility care as outlined on the resident's care plan. The resident fell and experienced discomfort.

The Director of Resident Care (DRC) acknowledged staff had not followed the resident care plan, resulting in the resident's fall with injury.

Sources:

Critical incident, clinical record, plan of care, risk management audit, interview with DRC and staff

WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57
Pain management
s. 57.
(1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures.
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.
(2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to follow their program related to pain management for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee was required to have a pain management program in place and ensure the program was complied with.

The home's pain management program, NPC D-15, effective April 8, 2024, stated (in part): that registered staff were to complete a weekly pain assessment utilizing a clinically appropriate instrument, when a resident had new or worsening pain with a severity of four or greater or when a resident's pain was not relieved by initial interventions. In addition to this, registered staff were to follow up on the effectiveness of the pain medication administration within one hour, using the numerical scale or painad.

Rationale and summary

A resident was receiving medication for pain management.

Pain assessments and monitoring of the residents pain were not completed per the home's pain policy for a period of time.

The Director of Resident Care (DRC) acknowledged the home had not followed their pain management program with respect to completion of pain assessments.

Failure to follow the pain program related to assessment and reassessing of a residents pain may result in prolonged unrelieved pain for residents.

Sources:

resident clinical record, Pain management program NPC D-15, effective April 8, 2024, interviews with DRC, staff and residents.