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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 23, 2023

Inspection Number: 2023-1582-0002

Inspection Type:
Complaint
Critical Incident System

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**
Sharon Perry (155)	Sharon M Perry Digitally signed by Sharon M Perry Date: 2023.03.30 17:52:42 -04'00'

Additional Inspector(s)
Yami Salam (000688)
Tanya Murray (000735)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 6-9, February 14-16, February 21, 22, 24 and 27, 2023, conducted on-site and February 23, 2023, conducted off-site.

The following intake(s) were inspected:
- Intake: #00015616 related to a fall resulting in an injury.
- Intake: #00019001 related to a resident to resident altercation.
- Intake: #00019700 related to an allegation of sexual abuse.
- Intake: #00018539 a complaint regarding foot and nail care.
- Intake: #00017297 and intake #00018822 complaints regarding responsive behaviours and infection prevention and control practices.
- The following intakes were completed in this inspection: Intake 00005764, Intake 00006170, Intake # 00002805, Intake 00005885 related to falls; and Intake # 00006174 related to an injury with a significant change in condition.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9) (a)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection were monitored in residents in accordance with any standard or protocol issued by the Director under subsection (2).
In accordance with the Minister's Directive: COVID-19 guidance document for long-term care homes in Ontario, the Licensee was required to ensure that all residents were assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

Rationale and Summary:

The IPAC Specialist said residents were assessed at least once daily for signs and symptoms of COVID-19, including having a daily temperature taken. They shared that this assessment was done in Point Click Care (PCC) in the assessment tool.

Review of a resident's COVID-19 Point of Care Risk Assessments (PCRA) showed that these were not completed until after a resident became symptomatic. Review of the resident's Treatment Administration Record (TAR), showed that staff did not sign that they completed the resident's PCRA for 26 days during a month. Review of Point of Care documentation that was completed by the Personal Support Workers (PSWs) showed that the resident did not have a PCRA done on every shift/prior to each interaction for 22 days during the month.

Failing to ensure that the resident was monitored daily for signs and symptoms of COVID-19 may have put other residents at risk as symptoms of COVID-19 could have been missed.

Sources: Resident's progress notes, TARs, PCC Assessments, County of Simcoe Investigation Briefing Note #2022-138, Country of Simcoe- COVID-19 Pandemic Enhanced Infection Control Practices Version 11.0, June 6, 2022.[155]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to ensure that resident #001, #005 and #006's areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

Rational and Summary

a) The home submitted a critical incident report (CIS) stating that resident #001 had a fall and that they had some bruising.

The skin assessments were not complete as they did not include the location, size or colour of the bruising. There was no skin assessment completed during a 13 day period.

Failure to complete weekly skin assessments, for resident #001's bruising may have impacted the treatment which could have put the resident at further risk of harm.

Sources: CIS report, resident #001's skin assessments, progress notes , Treatment Administration Records (TAR), Skin Care Program policy #NPC D-30, interviews with RN and other staff. [000688]

b) A CIS report was submitted to the MLTC regarding a resident to resident altercation. The Skin Assessment Tool done at the time of the incident, stated that resident #005 sustained an open area and it was being monitored.

The skin assessment tools for resident #005 completed two days and nine days post incident did not include any information regarding the open area.

The RN said that skin assessments were to be completed weekly for any area of altered skin integrity.

There was risk of harm to the resident as not reassessing weekly could have led to delayed treatment if the area worsened.

Sources: CIS report, resident #005's skin assessment tools, TARs, progress notes and interviews with RN and other staff. [155]

c) A CIS report was submitted to the MLTC regarding a resident to resident altercation. Assessment of resident #006 done at the time of the incident, showed that they had an open area that was bleeding. Measurements of the open area were taken, dressing applied, and the area was to be monitored.

The skin assessment tool done 7 days post incident, did not include any information about the open area.

The Director of Resident Care shared that if an area is open then there were to be wound assessments completed weekly that include measurements until the area is healed.

There was risk of harm to the resident as not reassessing weekly could have led to delayed treatment if the open area worsened.

Sources: CIS report, resident #006's skin assessment tools, TARs, progress notes and interviews with DORC. [155]

WRITTEN NOTIFICATION: Foot Care and Nail Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 39 (1)

The licensee failed to ensure that a resident received preventative and basic foot care services, including the cutting of the toenails, to ensure comfort and prevent infection.

Rational and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint regarding toenails not being cut on a regular basis to ensure comfort and prevent infection.

Review of a resident's plan of care stated that the resident required advanced foot care every six to eight weeks. Review of the resident's records showed that the resident received advanced foot care that included cutting of the toenails 11 weeks and 17 weeks apart. Three weeks later a medication was ordered for an infection.

Failure to complete the regular foot care, including cutting of the toenails for the resident may have impacted care which could have put the resident at further risk of harm.

Sources: Resident's skin assessments, progress notes, Treatment Administration Records (TAR), care plan, interview with RPN, Resident Care Supervisor and other staff. [000688]

COMPLIANCE ORDER CO #001 Behaviours and Altercations

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 60 (a).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Develop and implement a staffing plan that specifically addresses how the home will ensure interventions are implemented for a resident's behaviours. The plan shall be documented and kept available in the home.

b) The staffing plan shall include the dates, times and the name of the staff members assigned to ensure that interventions are implemented for the resident's behaviours. The staffing plan must remain in place until the resident's responsive behaviours that result in altercations and potentially harmful interactions with other residents are no longer demonstrated.

c) Ensure that alternative resources including but not limited to the MLTC-High Intenity Needs Fund, have been explored to supplement staffing for the resident. A record of those resources and actions taken are kept in the home.

Grounds
The licensee failed to implement interventions for a resident to minimize the risk of altercations and

potentially harmful interactions between and among residents.

During the inspection, a resident was observed in bed with resident #008. Resident #008 was crying softly and making gestures with their hands. The resident's alarm was ringing; however, staff were in the nursing station for report with the door closed. Inspector #000688 went to alert staff who then came and assisted the resident out of resident #008's bed.

An hour and nineteen minutes later, the resident was observed lying in resident #010's bed and staff were observed getting the resident out of the bed.

On another day during the inspection, the resident was observed in resident #010's bed. The resident was resistive to staff redirection so staff left the resident slipping in resident #010's bed.

Review of progress notes done for a twenty-seven day period, showed that the resident had ongoing responsive behaviours.

The resident's care plan documented that they needed constant redirection and reassurance.

A PSW said there was a risk that other residents on the unit could get hurt by the resident. Another PSW said that the resident is drawn to resident #008's room.

A PSW shared that some staff did some one-to- one with the resident but it was not consistent.

Three PSWs said the resident did not have one-to-one staff with them. DORC shared that they were not aware the resident was climbing onto things.

By the resident not having adequate interventions in place to manage their responsive behaviours it put the resident and other residents at risk of harm.

Sources: Observations on February 6, 8, and 22, 2023; resident clinical records, progress notes, care plan, Medication Administration Record (MAR), TAR, Point of Care documentation, interviews with PSWs, Director of Resident Care and other staff. [155]

This order must be complied with by April 17, 2023

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O.Reg. 246/22, s. 102 (9) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Assess the identified resident and if a runny nose and cough are determined to be baseline symptoms from a known condition document this in their plan of care. This assessment shall be part of the resident's clinical record.

b) Ensure that if the identified resident is having symptoms indicating the presence of infection, immediate action is taken to reduce transmission, isolate the identified resident and cohort as required.

c) Complete a weekly audit to ensure a) and b) are in place as required. The audit shall include the date the audit is completed, that name of the person completing the audit and response to any deficiencies found in the audit. The audit will be completed until 2 weeks post compliance due date if no deficiencies. If there are deficiencies then the audit shall continue until no deficiencies are noted. The audit shall be documented and kept available in the home.

Grounds
The licensee failed to ensure that immediate action was taken to reduce transmission, isolate residents and place them in cohorts as required.

Summary and Rational:
One resident living area had residents with COVID-19 symptoms. An identified resident was known to wander on this living area, including going into other resident rooms. Four days after residents were identified with symptoms of COVID-19, this living area was declared to be in a COVID-19 outbreak.

The same day that the living area was declared to be in a COVID-19 outbreak, the identified resident was transferred to another resident living area. The resident was to be isolated; however, the resident wandered the living area including going into other resident rooms.

On the same day that the resident was transferred, it was documented that the identified resident had symptoms of COVID-19.

The Respiratory/COVID-19 Investigation Line Listing Form indicated that the identified resident's symptoms were baseline symptoms; however, there was no documentation in the resident's clinical

records prior to the date of transfer, of these symptoms. PSWs #108, #119, #120, #121, Housekeeper #109, and RPNs #107 and #110 all said that the resident's symptoms were not baseline symptoms.

Five days after the identified resident was moved they tested positive for COVID-19 along with one other resident and a COVID-19 outbreak was declared in a second resident living area. This outbreak was case associated to the outbreak on the other resident living area.

The IPAC Specialist stated that when residents had baseline symptoms, the symptoms were to be documented in point click care in their care plan.

By failing to record symptoms indicating the presence of infection and taking immediate action to reduce transmission, isolate residents and place them in cohorts as required put other residents at risk as three other residents contracted COVID-19 resulting in one related death.

Sources: resident clinical records; COVID-19 guidance document for long-term care homes in Ontario; Simcoe County-Enhanced Infection Control Practices COVID-19 Pandemic 2020 v.11.0, dated June 6, 2022; December 2022 Monthly Surveillance Line Lists for living areas; Simcoe Muskoka District Health Unit Respiratory/Covid-19 Investigation Line Listing Forms for outbreak 2260-2022-72117 and interview with IPAC Specialist, and other staff. [155]

This order must be complied with by April 6, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.