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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 2, 2013	2012_168202_0028	T-910-12	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26, Midhurst, ON, L0L-1X0

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

SIMCOE MANOR HOME FOR THE AGED
1110 Highway 26, Midhurst, ON, L0L-1X0

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

VALERIE JOHNSTON (202)

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): December 18, 19, 21, 2012 (LTCH) and December 24, 27,31, 2012, January 02, 2013 (Office)

During the course of the inspection, the inspector(s) spoke with Administrator, Environmental Services Supervisor, Quality and Development Coordinator, Nurse Managers, Registered Nursing Staff, Personal Support Workers

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed home's policy titled, The Medication Pass dated 02/12

The following Inspection Protocols were used during this inspection:

Personal Support Services

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the SDM has been given an opportunity to participate fully in the development and implementation of the plan of care. [s.6(5)]

Clinical record review indicated that resident #002 was found on the floor in bedroom on March 11, 2012 at 0715 hours. Staff interviews and clinical record review revealed that Power of Attorney for Care was notified of the incident on March 27, 2012. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #001' s plan of care identifies this resident as requiring 2100 mls of honey thickened fluids daily, chokes easily, has poor dentition and is a high nutritional risk due to recurring aspiration pneumonia. An interview with an identified Registered staff member confirmed that resident #001's honey thickened fluid was packed and not sent with her/him on March 21, 2012, for a scheduled post surgical hospital appointment. Clinical record review and staff interviews confirmed that on March 21, 2012 between 1315 hours and 2000 hours resident #001 was not supplied honey thickened fluids during a planned post surgical hospital appointment. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy titled, The Medication Pass dated 02/12 is complied with. [s.8.(1)(b)]

The home's policy titled, The Medication Pass dated 02/12 directs staff to document on the Medication Administration Record (MAR) in proper space for each medication administered or document by code if medication not given. Clinical record review revealed that on March 21, 2012, resident #001's 1700 hour medications were signed as having been provided by an identified registered staff member. Staff interviews revealed that resident #001's 1700 hour medications for March 21, 2012 were found in the medication cart during the AM medication pass on March 22, 2012. [s. 8. (1)]

Issued on this 3rd day of January, 2013

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