Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Dec 9, 2020	2020_781729_0027	014685-20, 018604-20, 021498-20, 023927-20	Critical Incident System

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

KIM BYBERG (729), DANIELA LUPU (758)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 2 - 4, and December 7, 2020.

The following intakes were completed within the Critical Incident inspection:

Log #018604-20, related to a resident injury that required transfer to hospital with significant change in resident condition;
Log #021498-20, related to a resident injury that required transfer to hospital with significant change in resident condition;
Log #014685-20, follow-up to CO #001 from inspection #2020_781729_0009 related to resident plan of care, specifically fall prevention interventions;
Log #023927-20, follow-up to CO #001 from inspection #2020_781729_0022 related to safe and secure home.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Acting Associate Director of Care (ADOC), Quality Improvement Coordinator (QIC), RAI Coordinator, Royal Victoria Hospital - Chief of Clinical Operations, Royal Victoria Hospital - EOC Director/Incident Commander, Manager of Facility and Maintenance, Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping, and Residents.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, schedules, education records; and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home

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

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2020_781729_0022	729
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #001	2020_781729_0009	729

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident fell, a post-fall assessment was completed using a clinically appropriate assessment tool.

A resident was at high risk for falls and had a pattern of behaviour that resulted in falls. They required one person assistance for their care and transferring needs.

The resident was found on the floor and was assisted back to bed by two staff members. A few hours later, A Personal Support Worker (PSW) reported to the registered staff that during care they noted that the resident had pain and an injury and they required the assistance of two people, with the aid of a lifting device to transfer. No post fall assessment was completed as a result of the incident.

One day after the incident, the resident had increased pain their injury was assessed as being more severe, resulting in a significant change in their health condition.

After their fall, the resident was not assessed using a clinically appropriate assessment tool, which increased the risk that injuries and pain may not have not been identified and appropriate interventions implemented immediately.

Sources: critical incident system report, the resident's progress notes and care plan, incident report, documentation survey report v2 for September 2020, and interview with direct care staff and the DOC. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(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. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

The following is further evidence to support the order issued on July 17, 2020, during inspection 2020_781729_0009 with a compliance due date of October 30, 2020.

A Resident was at high risk for falls and was known to have behaviours that resulted falls. They had an unwitnessed fall that resulted in a significant change in their health status

During a three month period in 2020, the resident had three falls. The interventions to mitigate the risk for falls were often not effective. The care plan was revised, but no new strategies were considered in the revision of their plan of care for fall prevention for the past six months despite multiple falls.

Observations during this inspection revealed that the resident was left unattended by a PSW while in the bathroom with no fall prevention interventions in place, which put the resident at risk for a fall and injury.

Different approaches were not considered in the revision of the residents' plan of care to prevent falls and to monitor the resident which increased the risk of future falls and injuries.

Sources:critical incident system report, observations , the resident's progress notes, care plan, post fall assessments, and interviews direct care staff and the DOC. [s. 6. (11) (b)]

Issued on this 14th day of December, 2020

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

Original report signed by the inspector.