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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date August 4, 2022
Inspection Number 2022_1582_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Corporation of the County of Simcoe

Long-Term Care Home and City
Simcoe Manor Home for the Aged, Beeton

Lead Inspector
Robert Spizzirri (705751)

Inspector Digital Signature
Robert Spizzirri
Digitally signed by Robert Spizzirri
Date: 2022.08.04 15:03:20 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 25 – 29 and August 2 of 2022.

The following intake(s) were inspected:

- 010671-22 (complaint) related to admissions, continence, nutrition, and skin and wound.

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

- Admission, Absences & Discharge
- Continence Care
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Skin and Wound Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 55 (2) (b) (iv)

The licensee has failed to ensure that a member of the registered nursing staff reassessed a resident's skin breakdown weekly.

A Registered Staff assessed an area of skin breakdown on a resident. They documented it needed further monitoring.

A weekly assessment was not completed for a specific week.

Two Registered staff said an assessment was not completed.

There was risk of harm to the resident as not reassessing weekly could have led to delayed treatment if the skin breakdown was worsening.

Sources: Resident's assessment and other clinical records; and interviews with staff. [705751]

WRITTEN NOTIFICATION GENERAL REQUIREMENTS FOR PROGRAMS

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that with respect to the Skin and Wound Program, interventions for a resident are documented.

A resident's skin breakdown was assessed by a Registered staff who initiated a treatment for a medicated cream to be applied.

Registered and direct care staff did not document the application of the treatment. However, they said that the treatment had been applied as required.

A Registered staff acknowledged that they had not transcribed the treatment on the electronic system to document the cream being applied.

There was low risk to the resident when staff did not implement a method of documenting and tracking the application of the medicated cream.

Sources: Resident's administration record and other clinical records; and interviews with staff. [705751]

WRITTEN NOTIFICATION PLAN OF CARE

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NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCHA, 2021 s. 6 (1) (c)

The licensee has failed to ensure that plan of care set out clear directions to staff and others who provide direct care to a resident.

A resident was admitted with a medicated ointment to be applied to “affected areas”. A different medicated cream was initiated to be applied to a specific area of skin breakdown. The care plan did not contain any information related to the ointment and cream, and the areas they were to be applied to.

Both treatments were to be applied by the PSW staff. They indicated that they received their direction from the care plan.

A PSW said they did not know what “affected area” meant. Other PSW staff said they had not been using the ointment and only the cream.

A Registered staff confirmed the ointment and cream was not applied as directed. They acknowledged directions were not transcribed into the care plan.

There was risk of harm to the resident as improper treatments applied could have worsened the skin breakdown.

Sources: Resident’s care plan and other clinical records, and interviews with staff. [705751]