Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: November 23, 2023	
Inspection Number: 2023-1582-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Corporation of the County of Simcoe	
Long Term Care Home and City: Simcoe Manor Home for the Aged, Beeton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature**

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6 -10, 14, and 16, 2023.
The inspection occurred offsite on the following date(s): November 15, 2023.

The following intake(s) were inspected:

- Intake #00087168, and intake: #00091146, related to falls prevention and management
- Intake #00096832, concerns related to falls prevention and management.

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

Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff involved in a resident's care collaborated in the development and implementation of the resident's plan of care to ensure interventions were integrated and consistent with each other.

Rationale and Summary

A resident had a change in their condition and a referral was sent to the physiotherapist.

The physiotherapist documented the resident needed a specific level of assistance for two of their care needs and had a change in their risk for falls.

The resident's care plan did not include any information related to the change in the resident's condition and their risk for falls and no interventions were developed to mitigate this risk.

Two staff members said they were not aware of the change in the resident's falls risk or specific falls prevention interventions.

A few days later, the resident had an incident and sustained an injury.

The Director of Resident Care (DRC) said when changes in the resident's care needs and falls risk were identified, nursing staff and the physiotherapist were expected to collaborate to ensure the appropriate interventions were developed.

Staff not collaborating in the development and implementation of the resident's plan of care, increased the risk that appropriate interventions were not consistently provided and it may have contributed to the resident's incident.

Sources: a critical incident, a resident's clinical records, and interviews with a PSW, an RPN, the physiotherapist and the DRC. [758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 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 interventions implemented for a resident under Infection Prevention and Control program, and for a resident under Nursing and Pain Management programs, and the residents' responses to these interventions, were documented.

Rationale and Summary

A. A resident was placed on additional precautions and monitoring to minimize the risk of infection.

There was no documentation in the resident's plan of care to include any details related to the isolation precautions or the provision of monitoring and the resident's response to these interventions.

The DRC said any interventions provided to residents and the resident's response to interventions should be documented.

By not documenting the interventions related to the isolation precautions and monitoring, increased the risk that staff may not be aware of these interventions and may not provide them consistently. Additionally, not documenting the resident's response to monitoring made it difficult to evaluate the effectiveness of this intervention.

Sources: a resident's clinical records, and interviews with two PSWs, an RPN and the DRC.

B. A resident had a change in their condition and their risk for falls and a specific assistive device was provided.

i) There was no documentation in the resident's plan of care regarding of the use of the assistive device and the resident's response to this intervention. Additionally, there was no documentation related to the resident's change in their risk for falls.

ii) The resident had pain and scheduled analgesics were administered, however the resident's electronic medication administration record (eMAR) did not include any scheduled analgesic.

There was no documentation to indicate the resident's pain level, what analgesics were administered and the resident's response to the pain management interventions.

iii) A few days later, following an incident, the resident had pain and as needed (PRN) analgesic was administered.

A few hours later, the resident's existing pain worsened and had new pain to a different part of their body.

There was no documentation of the resident's pain assessments and the interventions provided when the resident's pain worsened or when they had new pain. Additionally, there was no documentation of the resident's response to the pain interventions provided.

The DRC said interventions and assessments provided to a resident and the resident's response to interventions should be documented.

By not documenting the interventions provided to a resident's related to the use of an assistive device, pain management and the resident's response to these interventions increased the risk that staff may not consistently provide the resident with the appropriate interventions and made it difficult to evaluate the effectiveness of these interventions.

Sources: a resident's clinical records, and interviews with a PSW, an RPN, and the DRC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to the person who made a complaint regarding operations of the home and resident care included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

A verbal complaint related to operations of the home and a resident's care was received by the home.

The response to the complainant did not include the Ministry's toll-free number for making complaints about the home and its hours of service and the contact information for the patient ombudsman.

The home's Resident Care Program Supervisor acknowledged that the response to the complainant did not include the above information as required.

By not providing the complainant with the Ministry's toll free number for making complaints and the contact information for the patient ombudsman, the complainant may not be aware and able to access these resources if needed.

Sources: the home's complaint records and interviews with an Administrative Assistant and the Resident Care Program Supervisor. [758]

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.

The licensee has failed to ensure that the response provided to the person who made a complaint regarding a resident's care included an explanation of what the home had done to solve the complaint.

Rationale and Summary

A complaint as specified in NC #003 was received by the home.

The response to the complainant did not include an explanation of the home's actions to resolve the complaint related to resident care.

By not providing the complainant with an explanation of what the home had done to solve the complaint, the complainant was not aware of the home's actions and was not satisfied with the response that was provided.

Sources: the home's complaint record, and an interview with the Resident Care Program Supervisor. [758]