

Ministry of Health
and Long-Term Care

Ministère de la Santé
et des Soins de longue durée



Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Toronto Service Area Office

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Division de la responsabilisation et de la
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Direction de l'amélioration de la performance
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Bureau régional de services de Toronto

55, avenue St. Clair Ouest, 8^{ième} étage
Toronto, ON M4V 2Y7

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OCT 27 2010

Ms. Hilary Mallett

Simcoe Manor Home for the Aged
Main Street East, P.O. Box 100
Beeton, ON L0G 1A0

Dear Ms. Mallett:

Please find enclosed the **Inspection Report-Public Copy** for an inspection conducted **July 13, 2010** under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the **Inspection Report-Public Copy** must be made available without charge upon request. The report will also be on file with the Toronto Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

for Amanda Williams, BSc., BASc., CPHI(C)
LTC Homes Inspector

Susan Squires, R.N., BScN
LTC Homes Inspector

Performance
Improvement and
Compliance Branch
Inspection Report

**Ministry of Health and Long-Term Care**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**Ministère de la Santé et des Soins de longue durée**Division de la responsabilisation et de la performance du système de santé
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Inspection Report under the LTC Homes Act, 2007		Rapport d'inspection prévue de la Loi de 2007 les foyers de soins de longue durée	
☒ Public Copy ☐ Licensee Copy		☐ Copie du Titulaire ☒ Copie de la Publique	
Date(s) of inspection/Date de l'inspection July 13, 2010		Inspection No/ d'inspection 2010_101_9573_13Jul103219 2010_109_9573_13Jul104400	Type of Inspection/Genre d'inspection Mandatory Report Critical Incident
Licensee/Titulaire The County of Simcoe Long-Term Care Home/Foyer de soins de longue durée Simcoe Manor Home for the Aged			
Name of Inspector(s)/Nom de l'inspecteur(s) Susan Squires (109) and Amanda Williams (101).			
Inspection Summary/Sommaire d'inspection			
The purpose of this inspection was to conduct a Mandatory Report/Critical Incident inspection			
The inspection was conducted by Susan Squires and Amanda Williams.			
The inspection occurred on July 13, 2010.			
During the course of the inspection, the inspector(s) spoke with: Administrator Director of Care Registered Nursing Staff PSW Staff			
The following Inspection Protocols were used in part or in whole during this inspection: Hospitalization and Death Inspection Protocol Responsive Behaviors Medications			
Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.			
6 - Findings of Non-Compliance were found during this inspection. The following action was taken: 6 - WN 1 - VPC 2 - CO			



The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit

VPC – Plan of correction/Plan de redressement

DR – Director Referral/Régisseur envoi

CO – Compliance Order/Ordres de conformité

WAO – Work and Activity Order/Ordres travaux et activités

WN#1: The Licensee has failed to comply with: **LTCHA, 2007, S.O 2007, c 8, s6 (10) (b). The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary**

Findings:

1. An identified plan of care was not revised to reflect current significant change in health status.

Inspector ID#: 101

Required Compliance Date: Immediately

WN#2: The Licensee has failed to comply with: **LTCHA, 2007, S.O. 2001, c 8, s 6 (1) (c). Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

Findings:

1. An identified plan of care does not provide specific individual interventions and strategies required.

VPC – Pursuant to LTCHA, 2007, S.O. 2007, c. 8, s. 152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance for the plans of care for responsive behaviors to be implemented voluntarily.

Inspector ID#: 109

Required Compliance Date: September 12, 2010

WN#3: The Licensee has failed to comply with: **O. Reg. 79/10, s131 (2). The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the**

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constitue un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

prescriber.

Findings:

1. One resident was administered a double dose of prescribed medication on a specific date resulting in a medication error.
2. The above noted medication error was not identified by the home until 3 days later, resulting in delay in follow up actions.

Compliance Order # 001 will be served on the licensee

Inspector ID#: 101

Required Compliance Date: Immediately

WN#4: The Licensee has failed to comply with: O. Reg. 79/10, s 53 (1) 3. Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviors: (3) Resident monitoring and internal reporting protocols.

Findings:

1. Resident with responsive behavior was placed on one to one monitoring. There was no tracking/monitoring tool completed for a resident who was placed on one to one monitoring.

Compliance Order #002 will be served on the licensee

Inspector ID#: 109

Required Compliance Date: August 27, 2010

WN#5: The Licensee has failed to comply with: The Licensee has failed to comply with: O. Reg. 79/10, s. 135 (1) (a) (b). Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Findings:

1. There is no documentation in the health record to indicate the physician or the SDM were notified of the medication error incident. Staff interviewed were unable to confirm whether the parties were notified.



The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constitue un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé: (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

Inspector ID#: 101

Required Compliance Date: September 12, 2010

WN#6: The Licensee has failed to comply with: O. Reg. 79/10, s 53 (1) 1. Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviors:

(1) Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other.

Findings:

1. Behavioral tracking not completed according to the homes protocol. Triggers for aggressive behaviors not identified for an identified resident.
2. Staff responsible for the care of the above noted the resident were unable to state what triggers resulted in responsive behaviors.

VPC – Pursuant to LTCHA, 2007, S.O. 2007, c. 8, s. 152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance for the written approaches to care including screening protocols, assessment, reassessment and identification of behavioral triggers for responsive behaviors to be implemented voluntarily.

Inspector ID#: 109

Required Compliance Date: September 12, 2010

CORRECTED NON-COMPLIANCE
Non-respectés à Corriger

Signature of Licensee of Designated Representative
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la
responsabilisation et de la performance du système de santé.

Title:

Date:

Date of Report (if different from date(s) of inspection).

Aug 17 2010
Signature (101) Signature (109)

ORDER(S) of an Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O.2007,c.8

Inspector Name:	Susan Squires (109) and Amanda Williams (101)
Inspection ID #:	2010_101_9573_13Jul103219 2010_109_9573_13Jul104400
Type of Inspection:	Critical Incident & Mandatory Reporting
Date Order Made:	August 12, 2010
Date Order Served:	August 12, 2010
Licensee:	The County of Simcoe
LTC Home:	Simcoe Manor
Name of Administrator:	Hilary Mallet

To The County of Simcoe, you are hereby required to comply with the following orders by the date set out below;

Compliance Order #: 001

Pursuant to O. Reg. 79/10, s131 (2). The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use by the prescriber.

Grounds:

1. One resident was administered a double dose of prescribed medication resulting in a medication error.
2. The above noted medication error was not identified by the home until 3 days later when the home completed an investigation into another incident involving the above identified resident. This resulted in delay in follow up action.

Inspector ID# 101

This order must be complied with by: September 17, 2010

Compliance Order #: 002

Pursuant to: O. Reg. 79/10, s 53 (1) 3. Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

(3) Resident monitoring and internal reporting protocols.

The licensee shall develop and implement resident monitoring and internal reporting protocols for all residents with responsive behaviors.

Grounds:

- A resident was not monitored following a serious incident.

Inspector ID# 109

This order must be complied with by: September 17, 2010

TAKE NOTICE:

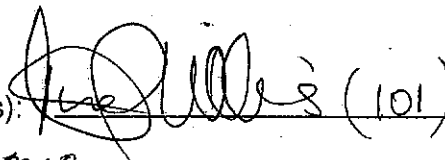
- A licensee has the right to request a review of this Order by the Director and to request a stay of the Order by the Director as per section 163 of the *Long-Term Care Homes Act 2007*.
- The request for review by the Director must be made in writing and within 28 days of the date the Order is served.
- The request for the Director's review must be delivered personally or by registered mail to the address below, or by fax to the number below.

Director

c/o Appeals Clerk
Performance and Improvement Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto ON M4V 2Y2

Fax: 416-327-7603

Signature of Inspector(s):

 (101)  (109)

Date: August 12, 2010

Time Order is Served: 3:03 pm