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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 5, 2018	2018_679638_0015	021687-18	Resident Quality Inspection

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

Georgian Manor Home for the Aged
101 Thompsons Road PENETANGUISHENE ON L9M 0V3

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

RYAN GOODMURPHY (638), TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 27 - 31, 2018.

The following intakes were inspected during this Resident Quality Inspection:
-Three logs were critical incidents the home submitted to the Director regarding outbreaks declared in the home;
-Two logs were critical incidents the home submitted to the Director related to falls which resulted in actual harm to the residents; and
-One log was related to a critical incident the home submitted to the Director related to a fracture a resident sustained of an unknown origin.

During the course of the inspection, the inspector(s) spoke with the Administrator, acting Director of Resident Care (DORC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant internal investigation notes, licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the outcomes of care set out in the plan of care were documented.

A CIS report was submitted to the Director related to an incident that resulted in an injury to resident #002, for which they were taken to hospital. The CIS report outlined that the resident fell and sustained injuries on a specific date in 2018. The CIS report indicated that resident #002 was placed on head injury routine to be monitored for signs and symptoms of a concussion upon their return from hospital.

Inspector #690 reviewed resident #002's health records and identified specific instructions which directed staff to monitor the resident for signs and symptoms of a concussion. The Inspector was unable to identify any documentation indicating that resident #002 was being monitored for a concussion, upon their return from hospital.

During an interview with Inspector #638, RPN #111 indicated that the concussion protocol followed the home's head injury routine. The RPN stated the head injury routine assessment was documented on a paper document and in the electronic progress notes.

In an interview with Inspector #690, RN #108 indicated that resident #002 should have had head injury monitoring upon their return from hospital. Upon reviewing the resident's health care records, the RN was unable to locate any documentation to indicate that resident #002 had been monitored for signs and symptoms of a head injury for their fall.

The home's policy titled "Head Injury - NPC F-40" effective date February 2011, identified the Charge Nurse will assess the resident's level of consciousness, pulse, respiration, blood pressure, pupil size/reaction, limbs and/or involuntary body movement, evidence of nausea, vomiting, headache, change in mental status, following the head injury routine;
-every 15 minutes for 1 hour;
-every 1 hour for 4 hours; and

-every 4 hours for 24 hours.
The policy indicated that this head injury routine was implemented whenever a head injury was suspected.

In an interview with Inspector #690, the acting DORC identified a specific head injury routine document located in resident #002's health care records. The Inspector observed the document which had no title, but listed the times upon which the resident was to be assessed. The acting DORC stated that this could have been the head injury routine document that coincided with the resident's fall, but it had no date. The acting DORC identified that they believed the document was initiated upon resident #002's return from hospital, but could not be certain due to the dates of the head injury routine not being identified. Furthermore, upon reviewing the identified head injury routine with the acting DORC, it was identified that the head injury routine document had no documentation to support any of the four hour checks were completed. The acting DORC indicated that staff should have documented the monitoring outcomes on the head injury routine document. [s. 6. (9) 1.]

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 the outcomes of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had their personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

On August 27, 2018, during a tour of the home, Inspector #690 noted;
-Two used and unlabelled sticks of deodorant, one used and unlabelled pair of nail clippers and one used and unlabelled hair brush on one of the unit's shower room;
-Two used and unlabelled sticks of deodorant and one used and unlabelled bar of soap on the same unit's tub room;
-Three used and unlabelled sticks of deodorant on a second unit's tub room;
-One used and unlabelled stick of deodorant and one used comb on the second unit's shower room; and
-Three used and unlabelled sticks of deodorant on a third unit's tub/shower room.

Additionally, on August 30, 2018, Inspector #690 noted four used and unlabelled sticks of deodorant and one used and unlabelled comb on the third unit's tub/shower room.

During an interview with Inspector #690, PSW #107 observed the unlabelled personal care items found on the first unit's tub room with the Inspector. The PSW verified that personal items such as roll on deodorant, nail clippers and hair brushes were supposed to be labeled with the resident's name.

In an interview with Inspector #690, the acting DORC verified that all residents' personal care items should have been labelled with the resident's name. [s. 37. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use by the prescriber.

Inspector #690 reviewed a medication incident report. The medication incident report indicated that resident #009 received a specific amount of an ordered medication in error as opposed to the ordered dose of the medication, which was one quarter the strength that was provided.

The home's policy titled “The Medication Pass - #3-6" dated January 2014, identified that each resident is to receive the correct medication in the correct prescribed dosage, at the correct time and by the correct route.

In an interview with Inspector #690, RN #108 identified that it was expected that all medications were administered in accordance with the directions of the prescriber.

In an interview with Inspector #690, the acting DORC identified that resident #009’s medication was not administered in accordance with the directions of the prescriber and that it was expected that all medications be administered according to the directions of the prescriber. [s. 131. (2)]

Issued on this 7th day of September, 2018

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

Original report signed by the inspector.