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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 26, 2019	2019_772691_0009	033424-18, 000157-19, 001303-19, 002372-19, 008059-19	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

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

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

JENNIFER NICHOLLS (691), SHANNON RUSSELL (692)

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): June 17-21, 2019.

The following intakes were inspected upon this Critical Incident Inspection:
-Two intakes submitted to the Director for missing and controlled substances; and
-Two intakes submitted to the Director for falls resulting in injury; and
-One intake submitted to the Director for alleged staff to resident abuse.

A complaint inspection # 2019_772691_0008 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Registered Nurses (RNs), Registered Practical Nurse (RPNs), Personal Support Workers (PSWs) and Residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, reviewed relevant health care records, and internal investigation documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

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)**

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. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following; A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action was taken if any discrepancies were discovered.

A Critical Incident Report (CIR) was submitted to the Director for a missing or unaccounted for controlled substance on an identified day. The CIR identified that during medication shift count on the identified unit, it was discovered, that resident #001 was missing an identified amount of medication. After completing the investigation, it was identified that the medication went missing on a specified date when RPN#118 was on shift.

A review of policy titled " Narcotic and Controlled Substances Administration Record", last revised October 01, 2018, identified that once per month, the staff performs an audit of the Narcotic and Controlled Substances Administration Records to determine if there are any discrepancies. Any discrepancies must be reported to the Director of Nursing/Care as soon as they are discovered.

Inspector #691 requested the Narcotic and Controlled Substance audits for the identified months from the Director of Resident Care (DRC).

In an interview with Inspector #691, the DRC identified that they could only locate the requested Narcotic and Controlled Substance audits for a specified time period. The Inspector and the DRC reviewed the provided Narcotic and Controlled Substance audits together, and determined that the identified months were missing. The DRC explained to the Inspector that they were not able to access the previous DRC information as the audits were done electronically.

It was further identified by the DRC, that the expectation of the DRC was to have the Narcotic and Controlled Substances audits done monthly, and confirmed that these could not be provided to Inspector at the time of inspection. [s. 130. 3.]

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 steps are taken to ensure the security of the drug supply, including the following; A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, any person who had reasonable grounds to suspect that abuse of a resident by anyone, the licensee or staff had occurred, immediately reported the suspicion and information upon which it was based to the Director.

On September 05, 2018, the Director informed licensees via a memo regarding Amendments to the reporting requirements memo of July 5, 2018. The memo highlighted

that the licensee must submit a report to the MOHLTC (Director) Monday to Friday, 8:30 a.m. to 4:30 p.m. by immediately initiating and submitting an on-line Critical Incident Report (CIR). At all other times the licensee must call the after-hours reporting line and complete a CIR form first thing the following business day.

A CIR was submitted to the Director on an identified date, for an allegation of staff to resident physical and verbal abuse that had occurred the previous evening, on an identified date. The CIR indicated that Personal Support Workers (PSWs) #105 and #110 had witnessed Registered Practical Nurse (RPN) #117 inappropriately treat resident #004's, resulting in the resident stumbling sideways into the wall. RPN #117 had also been witnessed to be speaking inappropriately towards resident #004.

The Inspector reviewed reports made to the after-hours reporting line by the licensee and was unable to locate one related to the incident, on the identified date.

Inspector #692 reviewed resident #004's electronic health care record, which identified a progress note from the specific date, that had been documented by RN #109. The RN documented that late that shift PSW #110 reported to them that RPN #117 had been physically and verbally inappropriate towards resident #004, causing the resident to become upset and agitated.

Inspector #692 reviewed the homes policy tilted, "Zero Tolerance of Abuse and Neglect", #ADM F-10, dated April 2017. The policy identified that when the Registered Nurse (RN) received an internal report from an employee on a suspected or actual incident of abuse, the RN will immediately report to the MOHLTC. The policy further indicated that after-hours (during the weekends, statutory holidays and evenings) the report must be submitted through the after-hours contact number, "refer to Appendix D for reporting certain matters to the Director".

In separate interviews with PSWs #105 and #110, they indicated that during the shift of the identified date, they both observed RPN #117 attempting to administer resident #004 their medications. PSW #105 indicated that resident #004 was expressing concerns regarding RPN #117 providing care. PSW #105 indicated that resident #004 exhibited responsive behaviors towards RPN #117, at which time the RPN inappropriately treated resident #004, resulting in resident #004 stumbling sideways into the wall, and was speaking inappropriately towards resident #004. PSW #110 identified that they reported the witnessed incident to RN #109 that shift. PSW #105 indicated that resident #004 expressed concern regarding RPN #117's conduct the day following the incident.

During an interview with Inspector #692, RN #109 indicated that PSW #110 reported to them on the shift of the specified date, that RPN #117 had been physically and verbally inappropriate towards resident #004. RN #109 indicated that if an allegation of abuse was reported to have had occurred after hours, the process was for the RN in charge to contact the manager on call and report the incident to the MOHLTC (Director) utilizing the after-hours number. RN #109 confirmed that they were to report the incident to the Director immediately upon becoming aware of the incident through the after-hours number, and that they did not.

In an interview with the DRC, they indicated that the incident in which RPN #117 was physically and verbally inappropriate towards resident #004 was expected to be reported immediately to the Director and it was not, therefore it was reported late. The DRC confirmed that RN #109 was aware of the reporting requirement guidelines and that they should have reported the incident immediately using the after-hours number, as the incident occurred after regular business hours. [s. 24. (1)]

Issued on this 2nd day of July, 2019

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

Original report signed by the inspector.