Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Jan 24, 2020	2020_772691_0001	023019-19, 023625-19, 024471-19	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)

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): January 6-10, 2020.

The following intakes were inspected upon during this Critical Incident System inspection:
-Three intakes submitted to the Director related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Associate Director of Resident Care (ADRC), Behavioural Supports Ontario staff (BSO), Registered Nurses (RNs), Registered Practical Nurse (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector 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:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

s. 19 (1).

Sexual abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A Critical Incident (CI) report, was submitted to the Director on an identified date, in which resident #001 was described as exhibiting a responsive behaviour of a sexual nature towards resident #003. The CI report identified that resident #001 had previously exhibited sexually inappropriate behaviors towards other residents.

A review of resident #001’s electronic progress notes demonstrated that on an identified date, resident #001 exhibited sexually inappropriate behaviors towards resident #003. Inspector #691 conducted a further review of the electronic progress notes which indicated that resident #001's responsive behaviors had been well managed prior to the identified incidents, however, within a identified time frame their were five documented incidents when resident #001 was seeking out residents and attempting to exhibit responsive behaviors of a sexual nature.

Inspector #691 continued to review resident #001’s electronic progress notes identified that another incident on an identified date, resident #001 was observed by RPN #107 in an identified area of the nursing home, exhibiting responsive behaviors of a sexual nature towards resident #002.

A further review of resident #001’s health care records by Inspector #691 indicated that following the initial incident of the sexual responsive behavior towards resident #002 on the identified date, the home initiated an identified intervention with resident #001.

The Inspector identified that PSW #110 was scheduled to provide the identified intervention on the identified date when resident #001 exhibited responsive behaviors towards resident #003.

During separate interviews with Inspector #691, PSW #103, PSW #104, PSW #105 and PSW #106 all indicated that resident #001 had a history of responsive behaviors towards residents, as indicated in their behavioral care plan. They further indicated that that their was an identified intervention for resident #001 to prevent resident #001 from exhibiting identified responsive behaviors of a sexual nature towards other residents.

PSW #103, PSW #104, PSW #105 and PSW #108 all identified that it was the expectation of the staff member implementing the identified intervention for the duration of the entire shift to ensure resident #001 would not display further sexual responsive behaviors towards residents.

During an interview with RPN #109, they confirmed that there was a physician's order for an identified intervention. RPN #109 confirmed to Inspector #691 that they were working on the identified date when PSW #110 had not implemented the identified intervention for resident #001 during that time resident #001 was observed to be exhibiting an identified responsive behavior towards resident #003.

During an interview with ADRC #102, they indicated that staff were to implement the identified intervention for resident #001 at all times as ordered. ADRC #102 confirmed that the home failed to protect resident #003 from abuse by resident #001.

In an interview with the DRC they indicated that it was their expectation that staff follow the behavioral care plan while caring for the residents. The DRC confirmed that there was an identified intervention in place to be implemented after the initial incident with resident #001 to protect residents. The DRC identified that PSW #110 did not implement the identified intervention and resident #001 sought out resident #003 and displayed an identified responsive behavior of a sexual nature towards resident #003. The DRC confirmed that the home did not follow through with the appropriate care planned interventions for resident #001 and did not protect resident #003 from abuse. [s. 19. (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 every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented. O. Reg. 79/10, s. 53 (4).

A CI report was submitted to the Director on an identified date, in response to resident #001 exhibiting responsive behaviors towards resident indicating that resident #001 was observed exhibiting a responsive behavior of a sexual nature towards resident #003. Please see WN #1, finding #1, for further details.

A) Inspector #691 reviewed resident #001 progress notes, and physician orders, which indicated resident #001 had a specific type of assessment initiated on an identified date. The Inspector reviewed the resident's specified type of assessment for an identified time period, and identified missing documentation on seven occasions.

Inspector #691 reviewed the home's policy titled "Nursing and Personal Care Policy Manual-Responsive Behavior Program" policy D-20 -Responsive Behavior Program", last revised September 2019. The policy directed staff to document in the resident health record accurately.

The Inspector reviewed the home's policy titled "PSW Roles and Responsibilities-PSW Documentation", last revised December 31, 2018. The policy directed PSW staff to participate in timely documentation. The policy indicated that a PSW, was required to complete documentation of identified as they occur.

The Inspector interviewed PSW #103, and PSW #108, as well as RPN #107 and RPN #110; all confirmed that residents who required the specified type of assessment had the documentation completed for an identified period of time, and confirmed that missing documentation indicated that staff did not complete as required.

Inspector #691 interviewed the ADRC, who verified that all staff were trained on documentation and could document on the specified type of assessment. The ADRC confirmed that it was the expectation that any staff member that worked on the unit, were to document for the entire shift. The ADRC acknowledged that the specified type of assessment for resident #001 was not completed as required.

Inspector #691 interviewed the DRC, who verified that all staff were trained on documentation and could document on the specified type of assessment. The DRC confirmed that it was the expectation that any staff member that worked on the unit, were to implement the specified type of assessment and document as indicated.The DRC confirmed the expectation was that when a resident required this type of assessment, that it would be completed. Together with the Inspector, the DRC reviewed resident #001's specified type of assessment, and the DRC acknowledged that it was not completed as required. [s. 53. (4) (c)]

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 ensure that all provisions of care, specifically DOS charting, is documented as required for each resident, to be implemented voluntarily.

Issued on this 24th day of January, 2020

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

Original report signed by the inspector.