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
Jul 28, 2020	2020_745690_0013	000862-20, 005968-20	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

TRACY MUCHMAKER (690)

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): July 21-24, 2020.

The following intake(s) were inspected upon during this Critical Incident System Inspection:
-One log, which was related to a critical incident that the home submitted to the Director related to an incident that caused an injury to a resident;
-One log, which was related to a critical incident that the home submitted to the Director related to a missing/unaccounted for controlled substance.

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

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

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring devices or techniques when assisting residents.

A Critical Incident (CI) report was submitted to the Director on an identified date, related

to an incident that caused an injury to a resident that occurred four days earlier. The CI report indicated that resident #001 was being provided with assistance by Personal Support Worker (PSW) #100 without the presence of a specified piece of equipment when an incident occurred. The CI report further indicated that the resident was subsequently having pain, and a diagnostic test indicated that the resident had an identified injury.

A review of the electronic progress notes on Point Click Care (PCC) indicated that resident #001 was being provided with assistance by PSW #100, when an incident had occurred and that Registered Practical Nurse (RPN) #102 assessed the resident and found no injury at the time. A further review of progress notes indicated that three days after the incident occurred, the resident was noted to have pain and swelling in an identified area and an diagnostic test was ordered, which identified a specified injury.

Inspector #690 requested the home's internal investigation notes related to the incident and identified a document addressed to PSW #100, dated five days after the incident occurred. The document described an incident that took place whereby; PSW #100 had provided assistance to resident #001, without the use of a specified piece of equipment and the resident had sustained an identified injury. A further review of the internal investigation notes identified an additional document addressed to RPN #102, dated six days after the incident occurred. The document described the incident that occurred and indicated that when a resident was being provided with a specified type of assistance, an identified piece of equipment must always be used.

In an interview with PSW #100 they indicated that they had provided resident #001 with a specified type of assistance without a specified type of equipment when an incident had occurred. PSW #100 further indicated that they had reported the incident to RPN #102 right away, and that RPN #102, assessed the resident at the time. In separate interviews with PSW #100, PSW #101, and PSW #108, they indicated that when providing the specified type of assistance to a resident, they must always use a specified type of equipment and failure to do so could result in harm to the resident and was unsafe.

In an interview with RPN #102, they indicated that PSW #100 had provided resident #001 with a specified type of assistance without a specified piece of equipment when an incident had occurred and the resident sustained an injury. In separate interviews with RPN #102, RPN #105, and RN #106, they indicated that when staff were providing a specified type of assistance, they must always use a specified piece of equipment and failure to do so could result in harm to the resident and was unsafe.

In an interview with the Director of Resident Care (DRC), they indicated that they only became aware of the incident after receiving the results of the diagnostic test that identified the injury and had started an investigation with staff. The DRC indicated that it was identified through the investigation that PSW #100 had provided resident #001 with a specified type of assistance without the use of a specified type of equipment. The DRC further indicated that it was the expectation that staff were to use the specified piece of equipment when providing a specified type of assistance and that resident #001 was not provided with a specified type of assistance safely. [s. 36.]

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 staff use safe transferring devices and techniques when assisting residents, to be implemented voluntarily.

WN #2: 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 provision of care was documented.

A CI report was submitted to the Director on an identified date, related to an incident that caused an injury to a resident that occurred four days earlier. The CI report indicated that resident #001 was being provided with a specified type of assistance without the use of a specified piece of equipment.

Please see Written Notification (WN) #1, for details.

A review of the electronic progress notes on PCC identified two progress notes, one that was created four days after the incident, and an additional note that was created six days after the incident, that described the incident that took place. The progress notes indicated that resident #001 was being provided with a specified type of assistance with a specified type of equipment when an incident occurred, and that RPN #102 assessed the resident and found no injury at the time. A further review of progress notes indicated that three days later, the resident was noted to have pain and swelling in an identified area and a diagnostic test indicated an identified injury.

Inspector #690 requested the home's internal investigation notes related to the incident and identified a document addressed to RPN #102, dated six days after the incident occurred . The document described the incident, and that the home became aware of the incident after the results of the diagnostic test was received. The document further identified a lack of documentation related to the resident's status and the incident and directed RPN #102, to document the incident in PCC, and complete an additional identified document.

In an interview with RPN #102, they indicated that PSW #100 had reported the incident to them when the incident occurred, and indicated that the resident may have sustained an injury as a result. RPN #102, indicated that they had assessed the resident at the time of the incident, but that they did not document the incident or report it to anyone, until after the DRC, had followed up with them and they were directed to complete the documentation related to the incident. RPN #102 indicated that they should have documented the incident, and reported it to the RN at the time the incident had occurred.

In an interview with the DRC, they indicated that they only became aware of the incident after receiving the results of the diagnostic test that identified an injury and had started an investigation with staff. The DRC indicated that they had followed up with RPN #102, and had directed them to go back and document the incident in PCC that occurred on the identified date. The DRC further indicated that when an incident occurs, it was the expectation that staff would document the incident, and any assessments at the time that the incident occurred. [s. 6. (9) 1.]

Issued on this 29th day of July, 2020

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

Original report signed by the inspector.