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

Sudbury Service Area Office
159 Cedar Street Suite 403
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Telephone: (705) 564-3130
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159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 18, 2021	2021_907692_0001	005795-21, 006648-21, 007809-21	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

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): July 19-23, 2021.

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 unexpected death of a resident;

-One log, which was related to a critical incident that the home submitted to the Director related to abuse of a resident by anyone that resulted in harm or a risk of harm to the resident; and,

-One log, which was related to a critical incident that the home submitted to the Director for an incident that caused injury to a resident for which the resident was transferred to the hospital and resulted in a significant change in the resident's health status.

Inspector, Karen Hill (704609) attended this inspection.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Acting Director of Care (A/DOC), Infection Prevention and Control (IPAC) Specialist, Environmental Services Supervisor (ESS), Housekeepers, 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 and resident to resident interactions, observed infection control practices, reviewed cooling requirements, 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:

Infection Prevention and Control
Medication
Personal Support Services
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **1 VPC(s)**
- **1 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 used safe techniques when assisting a resident.

A Personal Support Worker (PSW) assisted a resident alone with a specific activity of daily living (ADL); the resident sustained a fall, which resulted in a significant change in the resident's health status.

The resident's plan of care at the time of the incident, indicated that they required two-person extensive assistance for a specific ADL. A review of Point of Care (POC) documentation for a 30 day period, identified that the resident had been provided assistance for the specific ADL by one person on multiple occasions.

Sources: Critical Incident System (CIS) report; a review of a resident’s care plan and kardex; “Minimal Lift” policy; follow up question report in POC; internal investigation notes; staff personnel file; interviews with staff.

2. The licensee has failed to ensure that staff used safe techniques when assisting a resident.

A resident’s care plan indicated that they required two-person extensive assistance for the completion of a specific ADL. A review of POC documentation for a 30 day period indicated that the resident was provided assistance for the specific ADL by only one person on multiple occasions.

In separate interviews with two PSWs, they both indicated that they were to follow the resident's care plan when providing assistance with their ADLs. Both PSWs identified that if it was documented in POC that the support provided was one person, then the resident was provided assistance by only one staff member.

In an interview with the Acting Director of Care (A/DOC), they indicated that staff were to always follow what the residents' care plan indicated. They identified that the resident had not been provided the assistance as indicated; therefore, posing a significant safety risk to the resident.

Sources: A review of a resident's care plan and kardex; “Minimal Lift” policy; follow up question report in POC; Interviews with PSWs, the A/DOC, and other staff.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the assessments taken in response to a resident exhibiting responsive behaviours were documented.

A resident had exhibited a responsive behaviour towards another resident, resulting in an injury to the resident. A monitoring process was to be continued for the resident exhibiting responsive behaviours.

A review of the documentation for the resident, identified that the documentation was incomplete. During separate interviews with the direct care nursing staff, they all indicated that they had completed the specified monitoring process; however, they had not documented, and they should have.

Sources: CIS report; review of a resident's health care records; "Responsive Behaviours Program" policy; Interviews with nursing staff. [s. 30. (2)]

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 ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.3) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and O. Reg. 79/10, s. 20 (1.3).
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 79/10, s. 20 (1.3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the heat related illness prevention and management (HRIPM) plan for the home was revised and implemented during the period from May 15 to September 15.

On April 1, 2021, the Assistant Deputy Minister (ADM) informed licensees via a memo related to enhanced cooling requirements to the Ontario Regulations (O. Reg) 79/10 of the Long-Term Care Homes Act (LTCHA), 2007. The memo highlighted a summary of the recent amendments to the regulations and that the changes would come into effect on May 15, 2021. The changes included the implementation of their HRIPM plan on any day the outside temperature was forecasted to be, or anytime the temperature in areas of the home reached 26 degrees Celsius for the remainder of that day and the following day.

A review of the home's policy titled, "Extreme Temperature – Management of Risk", indicated that the licensee had not revised their plan to reflect the new direction by the Director.

The Interim Administrator and the Environmental Services Supervisor (ESS), identified during separate interviews with the Inspector that they had received the memo from the ADM related to the amendments for cooling requirements and had reviewed it with their Corporate office. Both the Interim Administrator and the ESS indicated that they thought the directions had not applied to their home, as the home was fully air conditioned; therefore, they had not revised the home's HRIPM plan to ensure it included risk factors for identifying heat related illnesses and procedures to protect residents from high temperatures.

Sources: Memo from the ADM, related to enhanced cooling requirements, dated April 1, 2021; the home's "Daily Checks" logs; the home's policy titled, "Extreme Temperature – Management of Risk"; Interviews with the ESS, and the Interim Administrator. [s. 20. (1.3) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature was measured and documented in writing, in at least two resident bedrooms in different parts of the home and in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

A review of the home's "Daily Check", logs for a 65 day period, identified the air temperature had been checked once daily at the nursing station on each resident home area (RHA).

The Interim Administrator identified in an interview with the Inspector that they had received the memo from the ADM related to the amendments for cooling requirements. They indicated that they had misunderstood the memo as they were not monitoring the air temperatures in different resident areas. They identified that this posed a risk to residents as the home was unable to ensure that residents were provided a comfortable environment.

Sources: Memo from the ADM, related to enhanced cooling requirements, dated April 1, 2021; the home's "Daily Check" logs; the home's policy titled, "Extreme Temperature – Management of Risk"; Interviews with the Interim Administrator. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the air temperature measured under subsection 2. was documented in writing, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A review of the home's "Daily Check", logs for a 65 day period, identified the air temperature had been checked and documented once daily.

During separate interviews with the ESS and the Interim Administrator, they both indicated the home was currently only documenting the air temperature once daily, in the morning, instead of three times daily, and that they were not currently in compliance with the new regulations.

Sources: Memo from the ADM, related to enhanced cooling requirements, dated April 1, 2021; the home's "Daily Check " logs; the home's policy titled, "Extreme Temperature – Management of Risk; Interviews with the ESS, and the Interim Administrator. [s. 21. (3)]

Issued on this 20th day of August, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	SHANNON RUSSELL (692)
Inspection No. / No de l’inspection :	2021_907692_0001
Log No. / No de registre :	005795-21, 006648-21, 007809-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 18, 2021
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Georgian Manor Home for the Aged 101 Thompsons Road, Penetanguishene, ON, L9M-0V3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Debbie Arbour

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with s. 36 of O. Reg. 79/10.

Specifically, the licensee must:

1) Review the policy with all nursing staff related to lifts and transfers. Provide hands-on re-training for all staff involved in transferring and positioning residents. This training shall include, but not be limited to, all types of transfers, and a demonstration of the entire transfer process;

2) The licensee will maintain a record of the hands-on re-training provided to staff, including the date of the demonstration, who facilitated the demonstration, and a record of attendance. This documentation will be provided to an Inspector when requested; and,

3) Complete weekly audits, on various shifts and units to ensure that staff are using safe transferring and positioning devices or techniques. This process shall be documented to include: the date and time of the audit, the result of the audit and any actions taken to rectify concerns identified from the audit. Conduct and document the audits until no further concerns are identified in the audits, for a two week period.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe techniques when assisting a resident.

A Personal Support Worker (PSW) assisted a resident alone with a specific activity of daily living (ADL); the resident sustained a fall, which resulted in a

significant change in the resident's health status.

The resident's plan of care at the time of the incident, indicated that they required two-person extensive assistance for a specific ADL. A review of Point of Care (POC) documentation for a 30 day period, identified that the resident had been provided assistance for the specific ADL by one person on multiple occasions.

Sources: Critical Incident System (CIS) report; a review of a resident's care plan and kardex; "Minimal Lift" policy; follow up question report in POC; internal investigation notes; staff personnel file; interviews with staff. (692)

2. The licensee has failed to ensure that staff used safe techniques when assisting a resident.

A resident's care plan indicated that they required two-person extensive assistance for the completion of a specific ADL. A review of POC documentation for a 30 day period indicated that the resident was provided assistance for the specific ADL by only one person on multiple occasions.

In separate interviews with two PSWs, they both indicated that they were to follow the resident's care plan when providing assistance with their ADLs. Both PSWs identified that if it was documented in POC that the support provided was one person, then the resident was provided assistance by only one staff member.

In an interview with the Acting Director of Care (A/DOC), they indicated that staff were to always follow what the residents' care plan indicated. They identified that the resident had not been provided the assistance as indicated; therefore, posing a significant safety risk to the resident.

Sources: A review of a resident's care plan and kardex; "Minimal Lift" policy; follow up question report in POC; Interviews with PSWs, the A/DOC, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual harm as one resident was provided assistance by one person, when they required two people for the specific ADL, resulting in a significant injury and actual risk of harm for improperly providing the required assistance to a second resident.

Scope: The scope of this non-compliance was a pattern because staff did not use safe transferring or positioning devices or techniques when they assisted two out of three residents reviewed during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 36 of the O. Reg. 79/10 of the LTCHA, and a Written Notification (WN) and a Voluntary Plan of Correction (VPC) were issued to the home. (692)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

Service Area Office /
Bureau régional de services : Sudbury Service Area Office