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
Oct 25, 2021	2021_829757_0022	011537-21	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

DAVID SCHAEFER (757)

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): October 19-20, 2021.

The following intake was inspected during this Critical Incident System inspection:
-one intake related to a resident fall which resulted in injury and a subsequent transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Acting Director of Resident Care (ADRC), Infection Prevention and Control (IPAC) Specialist, Housekeepers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, resident-to-resident interactions, and reviewed relevant resident health care records, the home's internal investigation file, incident reports, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Safe and Secure Home

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care laid out in a resident's plan of care was provided to the resident as specified in the plan.

A) A resident's care plan identified that they were required to have a number of safety interventions provided for their care. The resident was involved in multiple incidents where these interventions had not been implemented. The Acting Director of Resident Care (ADRC) identified that Personal Support Worker (PSW) staff were required to ensure that these interventions were properly in place and that the failure to implement these interventions created a potential risk of harm for the resident.

B) A physician ordered a trial of a safety device for a resident. The safety device had not been implemented for the resident at the time of inspection. A Registered Nurse (RN) had received and transcribed the order; however, did not follow-up to have this safety device implemented into the resident's care. The failure of the licensee to implement this safety device created a potential risk of the resident sustaining an injury.

Sources: Observations of a resident; a resident's care plan, progress notes, assessments, and physician's orders; and interviews with the ADRC, an RPN, and other relevant staff members. [s. 6. (7)]

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 care laid out in a resident's plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept locked when they were not being supervised by staff.

Two supply rooms containing only incontinence products on two resident home areas were observed to be unlocked, not in use, and unsupervised. A PSW and an RPN confirmed that these doors were unlocked, and were required to be locked when not being used or supervised. A PSW identified that the night staff were required to stock the home areas with incontinence products and were to ensure that the doors were locked when not in use.

Sources: Observations of resident home areas; and interviews with PSWs, an RPN, and the ADRC. [s. 9. (1) 2.]

Issued on this 26th day of October, 2021

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

Original report signed by the inspector.