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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date August 31, 2022
Inspection Number 2022_1549_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ________________

Licensee
Georgian Manor Home for the Aged

Long-Term Care Home and City
Georgian Manor Home for the Aged, Midland

Lead Inspector
Sylvie Byrnes #627

Inspector Digital Signature

Additional Inspector(s)
Shannon Russel #692
Amy Geauvreau #642

The inspection occurred on the following date(s): July 25-29, 2022.

The following intake(s) were inspected:

- Five intakes related to resident to resident abuse;
- Four intakes, related to falls;
- One intake related to a complaint regarding a fall; and,
- One intake related to a complaint submitted regarding resident to resident verbal abuse.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Responsive Behaviours
- Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (7)

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

Rationale and Summary

A resident was provided with a specific type of equipment which was identified in their plan of care. When the resident was transferred rooms, they were not provided with the specific type of equipment. The Director of Care (DOC) stated that the resident should have been provided with the specific type of equipment as was indicated in their plan of care.

Sources: Two CIS reports, complainant email; Bed Risk Assessment; progress notes; interviews with DOC, Registered Nurse (RN), and Registered Practical Nurse (RPN), and other staff. [642]

WRITTEN NOTIFICATION: BED RAILS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.Reg. 79/10, s. 15 (1) (a)

The licensee has failed to ensure that where bed rails were used for a resident, the resident was assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Rationale and Summary

A resident had bedrails installed on their bed. Although the home completed a bedrail risk assessment for the resident, an assessment of entrapments zones, latch reliability and other safety issues related to the use of bed rails were not assessed. The DOC identified that the assessments should have been completed after bedrails were applied.

There was moderate risk to the resident as the home used standardized beds and yearly bed assessments were completed on all beds.

Sources: Critical Incident System report; Bed Risk Assessment; policy "Bed Entrapment" January 2020; Guidance Document, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"; progress notes for a resident; interviews with DOC, RN, and RPN, and other staff. [642]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 24 (1)

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or a risk of harm to the resident, had occurred, immediately reported the suspicion and the information upon which it is based to the Director:

Rationale and Summary

A resident was observed exhibiting responsive behaviours toward another resident. The incident was reported to the Director two days later. The DOC stated they were only informed of the incident two days later; however, staff should have called the after-hours action line when the incident occurred.

The late reporting of the incident caused no harm to the residents.

Sources: CIS report, progress note, home's policy titled, "MOHLTC Critical Incident Reporting",, LTC CIS reporting Flow Chart/ Abuse/Neglect reporting. [627]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 19 (1)

The licensee has failed to ensure a resident was protected from abuse by anyone.

Rational and Summary

Staff observed a resident exhibiting sexual responsive behaviours toward another resident. There was no impact to the resident.

Sources: CIS report, progress note, home's policy titled, "MOHLTC Critical Incident Reporting", LTC CIS reporting Flow Chart/ Abuse/Neglect reporting, interviews with DOC and other staff members [627]

COMPLIANCE ORDER [CO#001]: ALTERCATIONS AND OTHER INTERACTIONS

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: O. Reg. 79/10, s. 54 (b)

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The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act.

Compliance Plan [*FLTCA, 2021, s. 155 (1) (b)*]

Specifically, the licensee shall:

Prepare, submit and implement a plan to ensure that the responsive behaviour interventions identified in residents' plan of care are implemented.

The plan must include but is not limited to:

-The person(s) responsible for monitoring that the residents' responsive behaviour interventions are implemented.

Please submit the written plan for achieving compliance for inspection #2022_1549_0001, to Sylvie Byrnes, LTC Homes Inspector, MLTC, by email to SudburySAO.moh@ontario.ca by September 12, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that steps were taken to minimize the risk of potentially harmful interactions between and amongst residents, by identifying and implementing interventions.

Rationale and Summary

a) Staff members responded to a resident yelling out. The resident had been moved location and another resident with responsive behaviours was close by. At the time of the incident, the resident who exhibited responsive behaviours was to have been provided with a specific intervention. The DOC verified that the specific intervention had not been provided.

Residents were at risk when a resident who exhibited responsive behaviour was not provided with a specific intervention.

Sources: CIS report, Physician's orders, home's policy titled, "Responsive Behaviour Program", resident's care plan, interviews with DOC and other staff members. [627].

b) Two residents had a physical altercation. At the time of the incident, one of the residents was to have been provided with a specific intervention. The DOC verified that the specific intervention was not in place due to staffing shortages.

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The residents were placed at risk when they were not provided with a specific intervention as was indicated in their plan of care; a resident sustained mild injuries.

Sources: CIS report; residents' care plans; the home's internal investigation notes; the home's policy titled, "Responsive Behaviours Program; and interviews with a PSW, Registered Practical Nurse (RPN), Registered Nurse (RN) and the DOC. [692]

c) Two residents had a physical altercation when one of the residents became frustrated with the task at hand. One of the residents was to have a specific intervention in place. The DOC acknowledged that the specific intervention was not place at the time of the incident.

Residents were placed at high risk when the resident was not provided the specific intervention as was identified in their plan of care. The resident sustained minor injuries.

Sources: CIS report; residents' health care records and care plans; the home's internal investigation notes; the home's policy titled, "Responsive Behaviours Program; and interviews with a Dietary Aide (DA) Registered Practical Nurse (RPN), Registered Nurse (RN), and the DOC. [692]

This order must be complied with by
September 30, 2022.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch

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

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Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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