Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: June 6, 2024

Inspection Number: 2024-1549-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: Corporation of the County of Simcoe

Long Term Care Home and City: Georgian Manor Home for the Aged, Penetanguishene

Lead Inspector	**Inspector Digital Signature**
Sylvie Byrnes (627)	Sylvie Byrnes Digitally signed by Sylvie Byrnes Date: 2024.06.06 14:10:02 -04'00'

Additional Inspector(s)
Justin McAuliffe (000698)
Jennifer Allen (706480)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13-17, 2024

The following intake(s) were inspected:

- One intake related to a Proactive Compliance Inspection.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration

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Residents' and Family Councils
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the continuous quality improvement (CQI) initiative report contained a written record of how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary

The Administrator stated that the results of the surveys were shared to the residents and their families, Residents' Council, Family Council, and members of the staff of the home by being posted on the staff information and the Friends and Family boards and read out at the Resident and Family councils.

The home's CQI Report did not include a written record of how and the dates when, the results of the survey were shared to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Sources: A Quality Improvement Plan Report; Interviews with the Administrator and the Resident council president. [706480]

Date Remedy Implemented: May 17, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken

during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the CQI initiative report contained a written record of the dates the actions taken to improve the LTCH based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, were implemented, and the outcomes of the actions.

Rationale and Summary
A review of the home's CQI report, published on their website on May 13, 2024, did not include a written record of the dates the actions taken were implemented related to the results of the satisfaction surveys taken in 2022, and the outcomes of those actions. The Administrator stated that actions to improve the LTCH were based on the provincial priority issues.

Sources: CQI Report; Interviews with the Administrator
[706480]

Date Remedy Implemented: May 17, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care for a

resident, was provided to the resident as specified in the plan.

Rationale and Summary
A resident was provided with a food item during meal service although their care plan indicated that they were not to receive this specific food item. The Registered Dietitian (RD) indicated that the resident was not to be provided with the specific food.

The resident was at increased risk when they were provided with the specific food item at a meal service.

Sources: Observation of the meal service; record review of a resident's care plan and the home's policy titled, "Plan of Care", #NPC A - 25; interviews with an Activity staff member, Dietary Aid, RD and Director of Care (DOC). [627]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure that the home had a dining service that included, at a minimum, providing residents with the eating aids required to safely eat and drink as comfortably and independently as possible.

Rationale and Summary

A resident's care plan indicated that the resident was to be provided with a specific eating aid during meal service. During a specific meal service, the resident was not provided with the eating aid. Registered Practical Nurse (RPN) #113 acknowledged that the resident should should have been provided their eating aid

There was low risk to the resident's well being when they were provided their eating aid.

Sources: Meal observation, record review of a resident's care plan; interview with Activation staff member, an RPN and DOC.
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