

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: August 1, 2023	
Inspection Number: 2023-1255-0002	
Inspection Type: Critical Incident System	
Licensee: Geraldton District Hospital	
Long Term Care Home and City: Geraldton District Hospital, Geraldton	
Lead Inspector Lauren Tenhunen (196)	Inspector Digital Signature

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 4-7, 2023.

The following intake was inspected:

- One Intake: for Improper/ incompetent care of a resident by staff.

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

Medication Management
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm was immediately reported to the Director.

Rationale and Summary

A Critical Incident report was submitted to the Director days after an allegation of improper/incompetent treatment of a resident that resulted in harm or risk to the resident, had occurred.

The home's policy titled, "Critical Incident Reporting Guidelines - Long-Term Care" last updated June 2023, provided direction regarding mandatory reporting requirements.

The LTC Nurse Manager reported the reason for the delay in reporting, was an error.

There was a low risk and low impact to the resident as this was related to reporting.

Sources: home's policy titled, "Critical Incident Reporting Guidelines - Long-Term Care" last updated June 2023; and an interview with the LTC Nurse Manager. [196]