Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, Dec 1, 2017	2017_685648_0012	021334-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

Long-Term Care Home/Foyer de soins de longue durée

GEORGIAN MANOR HOME FOR THE AGED
101 Thompsons Road PENETANGUISHENE ON 000 000

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

JOVAIRIA AWAN (648), GORDANA KRSTEVSKA (600), IVY LAM (646), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, and 29, 2017.

The following intakes were inspected concurrently with the Resident Quality Inspection:
Critical Incident Systems (CIS):
Log #008490-17 related to staff to duty to protect
Log #014725-17 related to responsive behaviours,
Log #033442-16 related to falls, and
Log #007173-17 related to plan of care.

Complaint:
Log #003046-17 related to staffing.

Follow-up to orders log #004340-17.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator (AA), Acting Director of Resident Care (ADRC), Nursing Manger (NM), Dietary Supervisor, Responsive Behaviour Lead, Quality and Development Home Coordinator (QDHC), Registered Dietitian (RD), Speech Language Pathologist (SLP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), Home Support Workers (HSW), Dietary Aides (DA), and Residents, Substitute Decision Makers (SDM), and family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_491647_0009	648
O.Reg 79/10 s. 50. (2)	CO #002	2016_491647_0009	648

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	Legendé 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system report identifying resident #057 to have exhibited inappropriate behaviour directed to resident #058.

A review of the written plan of care revealed resident #057 had a history of inappropriate behaviours toward staff and co-residents. The interventions directed staff to monitor the resident, provide redirection when needed, document each behaviour as it occurs, and notify appropriate individuals as applicable. Review of resident #057's clinical records identified a number of documented instances of inappropriate behaviour directed towards residents including resident #058. Documentation for the identified date of the incident revealed it as the first noted incident of resident #057 exhibit responsive behaviours toward a co-resident. The aforementioned documentation identified staff #154 responded to the inappropriate behaviour from resident #057 directed to resident #058.

An interview with staff #154, who witnessed the incident, revealed resident #057 was not separated from resident #058 following the initial exhibition of inappropriate behaviour leading up to the subsequent act of resident #058. Staff #154 acknowledged the inappropriate behaviour as an identified type of abuse, and that resident #058 had not been protected from resident #057.

An interview with the ADRC confirmed the home s expectation was to separate the residents immediately, in order to protect resident #058 from inappropriate behaviour by resident #057.

The severity of the non-compliance was actual harm or risk and scope was isolated. A review of the homes compliance history revealed that there had been previously issued non compliance to LTCHA, 2007, c.8 s. 19 (1) to the licensee as a Compliance Order during RQI inspection #2016_491647_0009 issued October 19, 2016. [s. 19. (1)]

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure the written plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of resident #008's clinical records identified he/she had a change in his/her continence care needs.Review of resident #008 s written plan of care in place at the time of the inspection identified resident #008 was incontinent and required the use of a continence product.

Interview with PSW #109 revealed resident #008's continence care needs and that he/she required the use of identified continence product. PSW #109 reported that resident #008's continence product was changed following a change in his/her continence level. Resident #008 s written plan of care was reviewed with PSW #109.

PSW #109 identified resident #008 continence interventions including the use of the documented continence product was inaccurate and did not reflect the use of the correct continence product for resident #008's.

Interview with RPN #103 and #126 identified resident #008's continence care needs and that he/she required an identified continence product brief which was assessed and determined by the homes continence care product representative. RPN #103 confirmed resident #008 no longer required the use of the continence product documented in his/her written plan of care. RPN #126 confirmed the written plan of care was not updated to reflect the current type of continence product used for resident #008 and acknowledged it provided unclear direction to staff for continence care.

Staff interviews related to resident #008 s continence care, and his/her written plan of care in place at the time of the inspection were reviewed with the ADRC. The ADRC confirmed the written plan of care did not provide clear direction to staff as it directed them to a continence product which was incorrect for resident #008 s assessed continence needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #005 was admitted to the hospital on an identified with an identified diagnosis related to nutrition and hydration. Review of the Speech Language Pathologist (SLP) assessment and recommended interventions, following the hospitalization, identified resident #005 was to be offered an identified fluid consistency to manage his/her change in swallowing ability.

Review of a dietary referral in the progress notes identified resident #005's fluid consistency was changed three days following the SLP recommendation. Review of Registered Dietitian (RD) #134 s follow up documentation revealed resident #005 did well on the modified fluid consistency, and that the RD had updated the resident s written plan of care for the resident to receive the identified fluid consistency.

Observations of resident #005 during the inspection period at meals, revealed that the resident was having a different fluid consistency than what he/she had been assessed for.

Interviews with dietary aide #105 and with Home Support Worker (HSW) #107 following the observations, confirmed the resident had received a different fluid consistency than what he/she had been assessed for.

Review of resident #005 s June and July eMAR revealed that the resident s diet was not entered into eMAR. Review of resident s September eMAR and Menustream records in the servery revealed the resident was to be provided a different fluid consistency than what he/she had been assessed for.

Interview with RD #134 revealed that he/she was notified of the resident s fluid consistency change from a dietary referral. RD #134 further revealed that he/she had assessed the resident and recommended to continue with the identified fluid consistency as recommended by the SLP. RD #134 revealed that she had not made a change to the physician s order, and had thought that registered staff would have already updated the resident s fluid consistency and notified the dietary supervisor through a dietary requisition form.

Interviews with dietary aide #105, dietary supervisor #117, and RPN #132 revealed that dietary aides use Menustream in the servery TV screen to identify what foods and fluids residents are to receive at meals, and PSWs use the Menustream on their tablets to identify what residents are to receive at snack times. Review of Menustream during the inspection revealed that the resident s fluid consistency a different fluid consistency than what he/she had been assessed for.

Interview with dietary supervisor #117 further revealed that changes to residents diets are made by the dietary supervisor after a dietary requisition form is provided from the nurses, or if the RD wrote changes for a specific resident on the dietary change list. The dietary supervisor further revealed that he/she was not able to locate records of instruction from nursing or dietary to change resident #005 s fluid consistency as assessed.

At morning nourishment pass during the inspection, the inspector observed that PSW #131 provided resident #005 with a modified fluid consistency beverage.

Interview with PSW #131 revealed that he/she had provided resident #005 with a different fluid consistency than what he/she had been assessed for and did not refer to the nourishment tablet to identify the resident s assigned fluid consistency.

Interviews with dietary supervisor #117 and the ADRC indicated that the written plan of care, the Menustream, and the eMAR were all components of the written plan of care for resident #005. The dietary supervisor #117 and ADRC confirmed that the residents plan of care did not provide clear direction to the staff when the fluid consistency for resident

#005 was initially changed following his/her hospitalization. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated andare consistent with and complement each other.

Resident #005 was admitted to the hospital on an identified with an identified diagnosis related to nutrition and hydration. Review of the Speech Language Pathologist (SLP) assessment and recommended interventions, following the hospitalization, identified resident #005 was to be offered an identified fluid consistency to manage his/her change in swallowing ability.

Review of dietary referral in progress notes following resident #005's revealed his/her fluid consistency was changed to the SLP's assessed recommendation. Review of Registered Dietitian (RD s) follow up note revealed resident #005's diet remained good, on the assessed fluid consistency prescribed by the SLP. Review of the resident's current written plan of care revealed the resident was the fluid consistency as identified by the RD and SLP. Review of resident #005's September eMAR and MenuStream in the servery revealed the resident was to receive a different fluid consistency than what he/she had been assessed for.

Observations of resident #005 on during the inspection on identified dates at meal times, revealed that the resident was having a different fluid consistency than what he/she had been assessed for.

Interviews with dietary aide #105 and with HSW #107 following the observations as noted above also confirmed the resident had received a different fluid consistency than what he/she had been assessed for.

Interview with RD #134 confirmed that he/she was aware of the resident s fluid change on the above mentioned dietary referral. The RD indicated that he/she had not made a change to the physician s order, and assumed that registered staff would have changed the resident s fluid consistency and notified the dietary supervisor through at dietary requisition form.

Interviews with dietary aide #105, dietary supervisor #117, and RPN #132 revealed that dietary aides use menu stream in the servery to identify what foods and fluids residents

are to receive at meals, and PSW staff use what was on the menu stream on their tablets to identify what residents are to receive at snack times.

Interview with dietary supervisor #117 further revealed that changes to residents diets are made by the dietary supervisor after a dietary requisition form is provided from the nurses, or if the RD wrote changes for a specific resident on the dietary change list. The dietary supervisor further revealed that he/she was not able to locate records of instruction from nursing or dietary to change resident #005 s fluid consistency following return from hospital and SLP assessment.

Interview with dietary supervisor #117 and the ADRC revealed that dietary and nursing staff did not collaborate in the development and implementation of resident #005's plan of care related to fluid requirement changes. [s. 6. (4) (b)]

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

Review of the resident s #009's clinical records at the time of the inspection revealed his/her behavioural status had changed since the last assessment. The resident had been experiencing socially inappropriate behaviours related to the provision of care.

Review of the resident #009's written plan of care revealed he/she was identified to have responsive behaviours and the interventions to manage this behaviour directed staff to provide care to the resident several times during day at identified intervals and when he/she exhibited the identified behaviours.

Review of the PSW daily record for the month of September 2017, revealed that the resident had been provide care on only one occasion on an identified shift. Interview with PSW #108 indicated he/she had provided the resident care once on his/her on the aforementioned identified shift, and he/she was anticipated that another staff may have provided care to the resident as well. PSW #108 identified that he/she did not provide care to resident #009 despite the resident exhibiting identified behaviours.

Interview with RPN #137 confirmed that the PSW's daily record indicated resident #009 had not been provided care as specified in the written plan of care for the identified shift.

Interview with the DOC confirmed that the PSW are expected to provide care to the resident as specified in the plan of care. [s. 6. (7)]

5. Observations were made during the RQI on an identified date during the Inspection Protocol (IP) Medication Administration for resident #053.

A record review for resident #053 revealed he/she was to receive an individualized treatment intervention which was to be administered as prescribed by the physician on an identified date.

Observations of resident #053 individualized treatment intervention identified it had been administered differently than prescribed by the residents physician. An observation and concurrent interview with RPN #136 confirmed the residents individualized treatment was had not been administered as prescribed. [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 plan of care set out clear directions to staff and others who provide direct care to the resident,
- to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, and
- to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone was immediately reported and the information upon which it was based to the Director.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system report (CIS) identifying resident #057 to have exhibited inappropriate behaviour directed to resident #058. The CIS identified a time and date for the reported incident.

An interview with the NM revealed the evening of the incident on the identified date, he/she was not able to send the CIS to the MOHLTC as the system would not permit the report to be sent, as noted on the CIS. The NM confirmed the MOHLTC was not contacted by phone at that time regarding resident #058 s alleged abuse.

An interview with the ADRC revealed the MOHLTC was to be notified immediately and in this instance the MOHLTC was notified the following day of the identified incident, and therefore the Director had not been immediately notified of resident abuse. [s. 24. (1)]

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 person who had reasonable grounds to suspect abuse or neglect of a resident, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that were the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriately assessment instrument that is specifically designed for assessment of incontinence.

Review of resident #008 clinical records identified he/she had a change in his/her continence level following admission. Further review of clinical records identified resident #008 be impaired in cognition and decision making which required staff supervision and cuing. The assessment further identified resident #008 had a history of falls and required extensive assistance for activities of daily living.

Review of resident #008 s clinical care records identified a Bladder and Bowel Assessment was completed at admission to determine his/her continence level and needs. The continence plan section of the assessment was noted to be blank and appeared incomplete in the document reviewed.

Review of resident #008 s written plan of care at admission, identified resident #008 was incontinent, required a continence product, and required staff assistance for continence care.

Review of the homes Continence Care and Bowel Management Policy (#NPC E-05, December 2016) identified a Bowel and Bladder Assessment was to be completed for residents on admission and for any change in condition that may affect bowel or bladder continence.

Interview with RPN #126 revealed continence related assessments for resident s in the home were completed on admission, a quarterly basis, if there was a change in continence level, and/or a change in mobility affecting a residents toileting needs. RPN #126 was unable to demonstrate resident #008 s had been assessed for his/her continence change on admission or afterwards following his/her change in continence, and confirmed that the assessment indicated above had not been completed.

The DOC identified and confirmed a Bowel and Bladder Assessment had not been completed following the change in resident #008 s continence level. [s. 51. (2) (a)]

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 were the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriately assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A CIS report was submitted to the MOHLTC for a resident-to-resident altercation, where resident #033 was witnessed to act inappropriately towards resident #032. Resident #032 sustained identified injuries as a result.

Review of the home's Quality Risk Rounds -- Meeting Agenda and Minutes, revealed that the identified incident was reviewed, and staff were directed to redirect the resident as

required and 1:1 staff monitoring was put in place.

Review of resident #033 s clinical records identified a resident to resident altercation between residents #033, #034, and #035 on an identified date.

Review of the resident s written plan of care and high risk round notes revealed resident #033 s interventions for identified behaviours prior to the identified incident reported to the MOHLTC included documented behaviour monitoring, redirecting the resident as appropriate if exhibiting behaviours, engaging with the resident, and to distract the resident. Interventions after the identified incident included the aforementioned interventions, with the addition of 1:1 monitoring for managing his/her behaviours.

Interviews with RPN #121 and RNs # 113 and #142 revealed that resident #033 s 1:1 staff was removed on the identified date of the documented incident with resident #034 and #035. RPN #121, and RN's #113 and 142 acknowledged that no additional interventions were provided for the resident beyond the documented behaviour monitoring and redirecting the resident as required, and that those interventions were not enough to minimize the risk of altercations and potentially harmful interactions between resident #033 and other residents without the 1:1 monitoring.

Interview with RNs # 113 and #142, and RPN/Responsive Behaviour Lead #144 revealed that the incident on the identified date may have been prevented if resident #033 s 1:1 staff was there to observe the resident for identified behaviours, and to intervene or redirect the resident earlier on before resident #033 had any interactions with residents #034 and #035.

Interview with RN # 113 and the DRC revealed that the 1:1 staffing should have been implemented for resident #033 to minimize the risk of altercations and potentia lly harmful interactions between resident #033 and other residents. [s. 55. (a)]

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of infection prevention and control.

During the RQI inspection period, observations were made for Inspection Protocol (IP) Medication Administration for resident #003, who was on isolation precautions. RPN #132 was observed to conduct an identified assessment of resident #003 his/her room, returned to the hallway medication cart and proceeded with the administer treatment without performing hand hygiene.

The policy for Prevention, Routine Practices, IFC B-50, dated August 2017, states hand hygiene should be performed after contact with body fluids and before and after performing aseptic or invasive procedures.

An interview with RPN #132 confirmed that he/she recognized that hand hygiene was not performed.

Further medication observations were made during the inspection period during a medication pass, for resident #051 and resident #052. RPN #136 was observed to conduct an identified assessment for resident #052. Hand hygiene was not observed to be performed following the, before resident #052 s was provided additional treatment. In addition, hand hygiene was not performed before medications were prepared for resident #051 and following administration to this resident.

An interview with RPN #136 confirmed hand hygiene had not been performed before and following contact with resident #052 during identified assessments and treatment administration, and following medication administration to resident #051 as noted above.

An interview with the ADRC confirmed the home s expectation was that hand hygiene be performed before and after resident contact. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control, to be implemented voluntarily.

WN #7: 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 failed to ensure that actions taken with respect to a resident under a program including interventions are documented.

Record review of resident #002 s clinical records identified he/she had an identified skin imparity. Review of the treatment administration record (TAR) at the time of the inspection identified resident #002 was to receive skin care twice a week and as needed.

Review of resident #002 s POC documentation during the inspection period identified he/she routinely received a bath twice a week including a bath on an identified date, documented by PSW #115.

Interview with PSW #115 revealed residents with impaired skin integrity were providedidentified treatments per their plan of care by registered staff as routine practice following a bath or shower. PSW #115 reported he/she provided positioning assistance of residents to registered staff when identified treatments were completed. PSW #115 identified resident #002 had been provided a bath on the identified date, after which PSW #115 assisted registered staff during the prescribed treatment measure.

Interview with RPN #116 identified registered staff were expected to document provision of treatments in the residents TAR. RPN #116 revealed resident #002 received an identified treatment on his/her bath days twice a week and as needed. RPN #116 reported he/she had provided a treatment to resident #002 s on two identified dates during the inspection period. RPN #116 reviewed resident #002 s TAR for the identified dates and confirmed he/she had not documented the treatment changes for resident #002, and did not meet the homes expectation to document provision of skin care.

Interview with the homes ADRC and the NM identified residents with impaired skin integrity were to be provided dressing changes on their bath days as per the homes process. The ADRC and NM revealed registered staff were expected to complete documentation following the provision of skin care to residents as per the homes process. Discrepancies of staff accounts for the provision of skin care, and absent documentation of skin care related to resident #002 were reviewed with the ADRC and NM for clarification. The ADRC and NM acknowledged documentation and reporting discrepancies identified resident #002 s skin care had not been appropriately documented in the residents TAR as per the homes process and legislative requirements.

The licensee failed to ensure that actions taken with respect to a resident under a program including interventions are documented. [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system report identifying resident #057 to have exhibited inappropriate behaviour directed to resident #058.

Review of resident #057's clinical records identified he/she presented with impaired cognition and impaired decision making.

A review of the written plan of care revealed resident #057 had a history of inappropriate behaviours toward staff and co-residents. The interventions directed staff to monitor the resident, provide redirection when needed, document each behaviour as it occurs, and, notify appropriate individuals as applicable. Review of resident #057's clinical records identified a number of documented instances of inappropriate behaviour directed towards co-residents including resident #058. Documentation on the identified revealed it as the first noted incident of resident #057 exhibiting a responsive behaviour toward a coresident. The aforementioned documentation identified staff #154 responded to the inappropriate behaviour from resident #057 directed to resident #058.

An interview with staff #154 and RPN #136 revealed that there had been no interventions identified or implemented to respond to resident #057 when he/she exhibited inappropriate behaviours.

An interview with the Assistant Director of Resident Care (ADRC) confirmed the that there were no interventions identified or implemented to ensure that steps are taken to prevent and minimize potentially harmful interactions between resident #057 and other residents in the home. [s. 54. (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The license failed to ensure that every medication incident involving a resident was reported to the resident, the resident s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During the RQI inspection of medication administration, the Medication Incident summary reports and individual Medication Incident Reports were reviewed for a period of three months in 2017. Four instance of medication incidents were reviewed and no documentation was found that the SDM was informed of the medication errors for the identified residents in each instance.

An interview with the ADRC confirmed to his/her knowledge that the SDMs were not notified of the aforementioned medication errors. [s. 135. (1)]

Issued on this 30th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOVAIRIA AWAN (648), GORDANA KRSTEVSKA (600), IVY LAM (646), JUDITH HART (513)
Inspection No. / No de l'inspection :	2017_685648_0012
Log No. / No de registre :	021334-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 28, Dec 1, 2017
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF SIMCOE 1110 Highway 26, Midhurst, ON, L0L-1X0
LTC Home / Foyer de SLD :	GEORGIAN MANOR HOME FOR THE AGED 101 Thompsons Road, PENETANGUISHENE, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Connie Sheridan

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 Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

Upon receipt of this order the licensee shall:
1. Provide re-education and training to all staff in the home related to abuse including clear examples of abuse and examples of warning signs of abuse;
2. Develop and implement a tool to evaluate the individual staff's understanding of abuse and warning signs of abuse; and
3. Develop, implement and submit a plan, that includes the above three requirements, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to Judith.Hart@ontario.ca by December 20, 2017.

Grounds / Motifs :

1. 1. The licensee failed to protect residents from abuse by anyone.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system report identifying resident #057 to have exhibited inappropriate behaviour directed to resident #058.

A review of the written plan of care revealed resident #057 had a history of inappropriate behaviours toward staff and co-residents. The interventions directed staff to monitor the resident, provide redirection when needed, document each behaviour as it occurs, and notify appropriate individuals as applicable. Review of resident #057's clinical records identified a number of documented instances of inappropriate behaviour directed towards residents including resident #058. Documentation for the identified date of the incident revealed it as the first noted incident of resident #057 exhibit responsive behaviours toward a co-resident. The aforementioned documentation identified staff #154 responded to the inappropriate behaviour from resident #057 directed to resident #058.

An interview with staff #154, who witnessed the incident, revealed resident #057 was not separated from resident #058 following the initial exhibition of inappropriate behaviour leading up to the subsequent act of resident #058. Staff #154 acknowledged the inappropriate behaviour as an identified type of abuse, and that resident #058 had not been protected from resident #057.

An interview with the ADRC confirmed the home s expectation was to separate the residents immediately, in order to protect resident #058 from inappropriate behaviour by resident #057.

The severity of the non-compliance was actual harm or risk and scope was isolated. A review of the homes compliance history revealed that there had been previously issued non compliance to LTCHA, 2007, c.8 s. 19 (1) to the licensee as a Compliance Order during RQI inspection #2016_491647_0009 issued October 19, 2016. [s. 19. (1)] (513)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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 Health and 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 28th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

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Name of Inspector / Nom de l'inspecteur : Jovairia Awan

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