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

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Original Public Report

Report Issue Date: August 21, 2024
Inspection Number: 2024-1549-0003
Inspection Type: Critical Incident
Licensee: Corporation of the County of Simcoe
Long Term Care Home and City: Georgian Manor Home for the Aged, Penetanguishene

INSPECTION SUMMARY

This inspection was completed between July 29, 2024, and August 2, 2024.

The following intakes were inspected:

-One intake related to an enteric outbreak in the home; and
-Four intakes related to allegations of resident abuse.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a registered staff member who had reasonable grounds to suspect abuse of residents that resulted in harm to the residents, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

A resident became physically responsive causing injury to co-residents.

The Critical Incident (CI) report was submitted to the Director by the home one day late, when staff identified the potential abuse in documentation during the 24-hour shift report.

The registered staff member acknowledged that they did not notify the Director or the Registered Nurse (RN) because they were so busy during the shift that they forgot.

A Director of Resident Care (DRC) verified that the registered staff member should

have immediately notified the RN of the incident which would have resulted in an immediate report to the Director.

The home's failure to ensure that the registered staff member immediately reported their suspicion of abuse of co-residents to the Director presented no risk to the residents.

Sources: A resident's health care records; The home's policy titled "Zero Tolerance of Abuse and Neglect" last reviewed August 1, 2023; A CI report; Interviews with a DRC and other staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that a Personal Support Worker (PSW) implemented the strategies developed to manage a resident's responsive behaviours.

Rationale and Summary

A PSW failed to implement an intervention for behaviours when they assisted a resident to ambulate.

There was a low impact towards the resident when the PSW did not ensure the plan for responsive behaviours was implemented.

Sources: Interviews with a DRC and other staff; Record review of a resident's care plan.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak in the home, as defined in the Health Protection and Promotion Act.

Rationale and Summary

The Simcoe Muskoka District Health Unit declared an outbreak in the home, which a DRC verified was reported by the home to the Director the following day.

There was low impact to residents due to the licensee not reporting the outbreak immediately/same day to the Director, as the home communicated with the local

public health unit to manage the outbreak.

Sources: A CI report; Georgian Manor Infection Control Notification of Outbreak Checklist; Simcoe Muskoka District Health Unit Health Care Center Outbreak Management Checklist; Interviews with a DRC and other staff.