

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

Public Report

Report Issue Date: September 3, 2025

Inspection Number: 2025-1549-0005

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

The inspection occurred onsite on the following date(s): August 25-28, 2025.

The following intake(s) were inspected:

- Three intakes, related to allegations of incidents involving resident-to-resident abuse;
- One intake, regarding a fall of a resident resulting in injury; and,
- One intake, related to an infectious disease outbreak.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

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

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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 immediately report to the Director an allegation of resident-to-resident abuse.

A resident had exhibited a specific responsive behaviour towards another resident; however, the Director was not notified until the following day.

Sources: Critical Incident (CI) report; two resident's health care records; the home's investigation notes; and interviews with direct care and registered staff, and the Administrator.

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the implementation of any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Additional requirement 10.4 (h) of the IPAC Standard requires the licensee to ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as: (h) Support for residents to perform hand hygiene prior to receiving meals and snacks.

Specifically, on an identified date, the Inspector observed seven residents that had entered a dining room on an identified unit, and had not been offered or encouraged to complete hand hygiene prior to commencing consuming their meal service.

Sources: The Inspector's observation; IPAC Standard for LTCHs issued April 2022, last



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Fixing Long-Term Care Act, 2021**

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revised September 2023; the homes policy titled, "Hand Hygiene Program"; and interviews with direct care staff, and the IPAC Lead.



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