Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 17, 2021	2021_879621_0012	009222-21	Critical Incident System

Licensee/Titulaire de permis

Geraldton District Hospital
500 Hogarth Avenue West Geraldton ON P0T 1M0

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

Geraldton District Hospital
500 Hogarth Avenue West Geraldton ON P0T 1M0

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

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 13 - 14, 2021.

The follow intake was inspected upon during this Critical Incident System (CIS) Inspection:

- One intake related to the misuse/misappropriation of resident money.

During the course of the inspection, the inspector(s) spoke with the Long-Term Care (LTC) Manager, the Manager of Finance, the Accounts Receivable Clerk, a Registered Practical Nurse (RPN), a Personal Support Worker (PSW), the Ward Clerk, and residents of the home.

The Inspector also completed a daily tour of the resident care areas, observed the provision of care and services to residents, reviewed the home's investigation records, and applicable policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

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	Légende 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 O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home's temperature logs for 13 consecutive days identified missing temperature documentation for the designated common area and two resident rooms, 15 out of 39 (38 per cent), of times that were required.

The LTC Manager acknowledged that temperatures were not measured in all required areas, at the required times in the home.

Sources: The home's temperature logs; and an interview with the LTC Manager. [s. 21. (3)]

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 temperatures required to be measured under subsection (2) are documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

A CIS report was made to the Director for suspected misappropriation of money for three residents. Documentation identified that the residents' substitute decision-maker's (SDMs) were notified of the incident, however, there was no record to identify that the SDMs were immediately notified of the results of the investigation thereafter.

The LTC Manager acknowledged that while initial contact was made with the SDMs to inform them of the incident, they did not follow up with the SDMs after the investigation was completed to inform them of the results.

Sources: Review of a CIS report and home's investigation notes; and an interview with the LTC Manager and other relevant staff. [s. 97. (2)]

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 resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of every investigation undertaken under subsection 23 (1) of the Act, were reported to the Director.

A CIS report was made to the Director for suspected misappropriation of money for three residents. However, no update was provided to the Director outlining the results of the investigation thereafter.

The LTC Manager identified that they had completed the investigation, with the outcome unfounded for misappropriation of the residents' money, but did not update the CIS report with the results thereafter.

Sources: Review of a CIS report and homes investigation notes; and an interview with the LTC Manager and other relevant staff. [s. 23. (2)]

Issued on this 17th day of September, 2021

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

Original report signed by the inspector.