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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 26, 2014	2014_287548_0024	O-000841-14	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

FROST MANOR
225 MARY STREET WEST, LINDSAY, ON, K9V-5K3

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

RUZICA SUBOTIC-HOWELL (548), ANANDRAJ NATARAJAN (573), KELLY BURNS (554), MELANIE SARRAZIN (592), WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 8, 9,10, 11, 12, 15, 16, 17, 18, 19, 2014.

IN the course of the Resident Quality Inspection the inspectors conducted three Critical Incidents:Log#'s: O-01118-12,O-001969-12 and O-000156-12.In addition, one complaint was inspected, Log#: O-000234-14

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Regulated Nursing staff, Personal Support Workers, Life Enrichment Coordinator, RAI Coordinator, Activity Staff, Office Manager, Residents, Family Members, President of Family Council and President of Resident Council.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed three medication passes, observed one meal service, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The resident staff communication and response system activator button provided in the lounge at the end of the Elm wing corridor can not be easily seen, accessed and used.

The small black activator push button is located approximately 4 foot, 8 inches above the floor surface, adjacent to the lounge's doorway. The button is located by other switches and is not easily identifiable as part of the resident staff communication and response system. The push button is also challenging to access due to its height above the floor surface. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident staff communication and response system is available at each bath and shower in the large central bathing room. One activator switch is provided on a wall surface that is located between 2 bath tubs and one showering area. A wound up cord, which hangs approximately 18 inches down the wall, is provided on the identified system activator switch. [s. 17. (1) (d)]

3. The licensee has failed to ensure that the resident staff communication and response system is available in every area accessible by residents including:
-the large and the small dining rooms
-the hair salon
-the central lounge
-the program/lounge space located adjacent to room 44
-the lounge adjacent to room 3 [s. 17. (1) (e)]

4. The lack of availability of the resident staff communication and response system in areas accessed by residents is a potential risk to the health, comfort, safety and well being of residents who may not be able to call or have calls placed for assistance by staff or visitors. [s. 17. (1) (e)]

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 O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. On September 15, 16 and 17, 2014 illumination levels in resident areas were checked by Inspector 102. A hand held GE light meter was used. The meter was held 3 to 4 feet above the floor surface, with all available electric light fixtures turned on. Florescent lights were given a warm up period to reach full intensity.

A minimum level of 215.28 lux of continuous, consistent lighting is not provided in the corridors through out the home. The level of illumination provided is less than 50 % of the required illumination level throughout the majority of the central corridor which surrounds the center core lounge. Illumination levels in the Birch, Maple and Elm corridors ranges from less than 50 to 75% of the required illumination level between ceiling light fixtures, to greater than 215.28 lux underneath and in close proximity to the light fixtures.

A minimum illumination level of 215.28 lux is not provided throughout the majority of residents' bedrooms:
- within each bedroom and en-suite washroom, illumination levels ranged from less than 50 % to 75 % of the required level of
illumination unless in close proximity to the provided light fixtures;
-the illumination level was less than 50% of the minimum requirement of 215.28 lux in the vicinity of the domestic style bath tub in the large central tub room.

Note: in residents' bedrooms window coverings were closed and privacy curtains, where provided, were open when light levels were measured. The window curtains in residents' bedrooms were not lined and did not block out daylight creating a higher level of illumination than would be provided solely by the provided light fixtures.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments;to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life. [s. 18.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident accessible door leading from the large dining room into a non secure outside patio area is kept locked. The outdoor patio is surrounded by a fence; however, the two gates provided are not secured to preclude exit by a resident. [s. 9. (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 the resident accessible door leading from the large dining room into a non secure outside patio area is kept locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On September 8 to 10, 2014 while conducting a resident interview with inspector #554, the resident indicated that the resident had not received two baths during the week.Inspector #548 overhead a voiced complaint by Resident #009 indicating that a scheduled bath had not been provided.

It was noted that Resident's #002, #008 and #009 were to be provided two scheduled baths per week as per the bath list provided by the home.

Upon review of Resident #008 Observational Flow Sheet record, the scheduled bath

was to be provided to the resident on a specified day in August, 2014. It is noted that there is no documentation on the flow sheet indicating that the bath was provided on that day. Upon review of the Resident's #009 Observational Flow Sheet record, the scheduled bath was to be provided to the resident on a specified day in September,2014. It is noted that there is no documentation that the bath was provided on this day. Upon review of Resident #002 Observational Flow Sheet record, the scheduled bath was to be provided to resident on specified days in August,2014 and on a specified day in September, 2014. It is noted that there is no documentation that a bath was provided on these days.

During an interview with inspector #592 Resident #008 indicated that scheduled days for baths were on Sunday's and Wednesday's. The resident stated that last few Sunday's no baths were provided as the home had indicated they were short (staffed). The resident indicated that usually when staff are unable to provide a scheduled bath, the home would provide a bath for the next day. The resident indicated that sometimes a scheduled bath is not reorganized for the next day and that the resident is bathed the following week.

In an interview with #S116 and #S133, both stated that when they provide care to residents it is expected for them to record their initials on the appropriate square box on the Observational Flow Sheets for each resident assigned to them. Both indicated to inspector #592 that if there is no recording of initials on the designated square box for bathing, they could not tell if a bath had been provided.

In an interview the DOC indicated to inspector #592 that the home had identified a problem since March of this year with the recording of the documentation of the care provided to residents. The DOC indicated that Personal Support Workers were not recording when they were providing baths for their assigned residents, therefore it was impossible for the home to know if the residents were bathed twice a week, as required.

Upon showing the DOC the empty square box on Observational Flow Sheets for Resident's #002, #008 and #009, the DOC indicated that the residents should have been provided their baths as scheduled and that she was not made aware of these omissions. The DOC indicated that when notified of an omission of baths the resident is provided a bath the following day.

In an interview with the Administrator, she indicated to inspector #592 that the home

reinforced with the staff to record on the Observational Flow Sheets even if residents are refusing their baths. The Administrator indicated that she was aware that baths were not being recorded; therefore she was unable to determine if the residents were bathed at a minimum twice a week. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure accurate receipt of the drug used in the home, whereas, 10 vials of Morphine injectable were misappropriated from the home.

On August 23, 2012 the home became aware that 10 vials of Morphine Injectable were missing. The home informed the Ministry of Health and Long Term Care and informed the Police.

On September 19, 2014 the Director of Care (DOC) indicated that the home procedure for receiving medications and related pharmacy documentation included the delivery of these items to the home in zipped green canvas bags. The DOC indicated that regulated nursing staff members would sign the delivery manifest indicating receipt of the bags and place the bags in the locked medication room for later processing.

On September 19, 2014 the DOC confirmed that a regulated nursing staff member had received the pharmacy delivery on August 20, 2012, signed the delivery manifest for that day and placed two canvas bags in the locked medication room for processing at a later time.

It is noted that on August 20, 2012 that there is a delivery manifest from the home's pharmacy provider signed by a regulated nursing staff member of receipt of two green canvas bags. It is noted there is no signature of the person acknowledging receipt of the drug,10 vials of Morphine injectable, on behalf of the home.

As such, the home failed to ensure that all medications received were checked for accuracy. [s. 133.]

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 the accurate receipt of all drugs used in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 3 (1)11, by ensuring that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act has been fully respected and promoted specifically: As it relates to an individual's physical or mental health, As it relates to the provision of health care to the individual.

The following observations were made: on September 9, 2014, at approximately 08:40 am, the electronic medication administration record was left 'open' on the medication cart and was left unattended while registered staff left to administer medications; information pertaining to Resident #002 was visible.

On September 09, 2014, at approximately 12:57pm, the electronic medication administration record (eMAR) was observed to be left 'open', information pertaining to Resident #001's allergies, diagnosis, diet and preference of how medication is to be taken was visible. The information was visible for approximately 20 minutes.

During this time of one of the observations (specific to Resident #002) two visitors (male and female) and another resident walked past the medication cart where the eMAR information was visible. RN #S102, later in day was observed sitting at the nursing station charting in Mede-care (electronic records), #S102 got up and left desk, then returned to the desk within a matter of minutes, #S102 said to Director of Nursing 'can you just sign me off the computer, I forgot to lock the screen'. [s. 3. (1) 11. iv.]

WN #7: 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. (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 has failed to ensure that the care set out in the plan of care of Resident #11 was provided to the resident as specified in the plan.

During September 11- 12,2014 Resident #11 oral care was inspected.

Resident #11 current plan of care was reviewed by Inspector #573. Under the section Dentition/Oral it states that "Daily cleaning of teeth or dentures, or daily mouth care by Client or staff, do not put mouth swabs in resident's mouth as the resident will eat them. This is a choking hazard. Use a syringe with water to attempt to flush mouth after meals. Lay resident on side in bed and place a towel under a cheek and flush the oral cavity"

In the Resident's #011 room, Inspector #573 observed a written note which was posted against the wall above the resident bed saying "Please do not use mouth swabs as resident will swallow them.

On September 11th, 2014, the inspector interviewed registered nursing staff member #S121 regarding Resident #011 oral hygiene. #S121 indicated that daily cleaning of the resident's mouth included the use of a swab and rinsing it with a mouthwash.

On September 16th, 2014, the inspector interviewed registered nursing staff member #S119 about Resident #011, in relation to oral hygiene. Staff #119 indicated that daily cleaning of the teeth included the use of a mouth swab stick covered with a wet cloth.

During an interview registered staff #S102 that Resident #011 has a history of biting and chewing the sponge in the swab stick and that's the reason why mouth swab sticks should not be used.

On September 16th,2014 during an interview the DOC stated that the expectation of the registered nursing staff is to follow the written plan of care and not to use the mouth swab sticks for Resident #011 due to the chocking risk for the resident.

Resident #011's oral care set out in plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (6) The following persons may not be members of the Family Council:
1. The licensee, and anyone involved in the management of the long-term care home on behalf of the licensee. 2007, c. 8, s. 59 (6).
2. An officer or director of the licensee or of a corporation that manages the long-term care home on behalf of the licensee or, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129, as the case may be. 2007, c. 8, s. 59 (6).
3. A person with a controlling interest in the licensee. 2007, c. 8, s. 59 (6).
4. The Administrator. 2007, c. 8, s. 59 (6).
5. Any other staff member. 2007, c. 8, s. 59 (6).
6. A person who is employed by the Ministry or has a contractual relationship with the Minister or with the Crown regarding matters for which the Minister is responsible and who is involved as part of their responsibilities with long-term care home matters. 2007, c. 8, s. 59 (6).
7. Any other person provided for in the regulations. 2007, c. 8, s. 59 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that no staff member is a member on Family Council.

On September 11, 2014 during an interview the Life Enrichment Coordinator indicated the Family Council was initiated at the home when the Life Enrichment Coordinator had a family member at the home. The Life Enrichment Coordinator held membership on council for approximately three years.

On September 11, 2014 the Life Enrichment Coordinator provided to the inspector the current list of Family Council Members. It is noted that the Life Enrichment Coordinator is listed as a member on council.

On September 18 , 2014 the Administrator confirmed that the family member had not resided at the home for approximately three years and confirmed that the Life Enrichment Coordinator has maintained member status on council for approximately three years.

On September 16, 2014 the President of Family Council confirmed that the Life Enrichment Coordinator is a member of council for the last three years.

The Licensee failed to ensure that no staff member is a part of Family Council. [s. 59. (6) 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures have been implemented for the cleaning and disinfection of bath tub lift chairs. During the inspection on September 15, 2014, the frames supporting the back rests of lift chairs in each of the two central tub rooms were identified to be soiled with a dry soap-like residue which could be scraped off. Lift seats were rechecked on September 16. The residue remained evident.

Both lift seat backs were observed to be soiled on September 17,2014. Marks made by Inspector still present in the soap like film build up.It had been confirmed by several personal support workers that multiple resident baths had occurred in each bath tub

Procedures in place for the cleaning of the bath lift seats do not identify that the back rest and the frame supporting the back rest are to be cleaned and disinfected. [s. 87. (2) (b)]

2. During the inspection, several residents' rooms were identified to have lingering malodours.

The Environmental Services Manual was reviewed and discussions were held with Environmental Services staff. It was identified that procedures related to odour control are not in place for Environmental services staff to follow.

The licensee has failed to ensure that procedures have been developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure controlled substances are stored in a separate, double-locked stationary cupboard in a locked area.

On September 19, 2014 the DOC indicated that the home procedure for receiving medications and related pharmacy documentation included the delivery of these items to the home in zipped green canvas bags. The DOC indicated that registered nursing staff members would sign a delivery manifest indicating receipt of the bags and place the bags in the locked medication room for later processing.

On September 19, 2014 the DOC confirmed that the registered nursing staff member had received a pharmacy delivery on August 20, 2012, signed the delivery manifest and placed two canvas bags in a locked medication room for processing at a later time.

It is noted that on August 20, 2012 there is a delivery manifest from the home's pharmacy provider signed by a regulated nursing staff member of receipt of two green canvas bags.

On September 19, 2014 the DOC confirmed that the registered nursing staff that signed for receipt of the two canvas bags on August 20, 2012 was not aware of the bags contents. The DOC confirmed that the bags contents contained controlled substances.

As such, the home failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

Issued on this 13th day of November, 2014

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 26, 2014
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	FROST MANOR 225 MARY STREET WEST, LINDSAY, ON, K9V-5K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Connie Abrams

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

CO RE O REG s. 17(e) res staff communication and response system

The licensee will ensure that the resident staff communication and response system is available in every area accessible to residents.

Grounds / Motifs :

1. The resident staff communication and response system activator button provided in the lounge at the end of the Elm wing corridor can not be easily seen, accessed and used.

The small black activator push button is located approximately 4 foot, 8 inches above the floor surface, adjacent to the lounge's doorway. The button is located by other switches and is not easily identifiable as part of the resident staff communication and response system. The push button is also challenging to access due to its height above the floor surface. (102)

2. The lack of availability of the resident staff communication and response system
in areas accessed by residents is a potential risk to the health, comfort, safety and well being of residents who may not be able to call or have calls placed for assistance by staff or visitors.
(102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

CO re Reg s. 18 LIGHTING:

The licensee will ensure that required levels of lighting are provided in all areas of the long term care home including:
• A minimum of 215.28 lux of continuous consistent lighting in corridors;
• A minimum level of 215.28 lux in residents' bedrooms, ensuite washrooms and in the large central bathing room.

The licensee will provide a written progress report indicate the status of the lighting levels by Feb 28, 2015. This progress report must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Grounds / Motifs :

1. On September 15, 16 and 17, 2014 illumination levels in resident areas were checked by
Inspector #102. A hand held GE light meter was used. The meter was held 3 to 4
feet above the floor surface, with all available electric light fixtures turned on. Florescent lights were given a warm up period to reach full intensity.

A minimum level of 215.28 lux of continuous, consistent lighting is not provided in the corridors through out the home. The level of illumination provided is less than 50 % of the
required illumination level throughout the majority of the central corridor which surrounds the center core lounge. Illumination levels in the Birch, Maple and Elm corridors ranges from less than 50 to 75% of the required illumination level between ceiling light fixtures, to greater than 215.28 lux underneath and in close proximity to the light fixtures.

A minimum illumination level of 215.28 lux is not provided throughout the majority of residents' bedrooms:
- within each bedroom and ensuite washroom, illumination levels ranged from less than 50 % to 75 % of the required level of
illumination unless in close proximity to the provided light fixtures;
-the illumination level was less than 50% of the minimum requirement of 215.28 lux in the vicinity of the domestic style bath tub in the large central tub room.

Note: in residents' bedrooms window coverings were closed and privacy curtains, where provided, were open when light levels were measured. The

window curtains in residents' bedrooms were not lined and did not block out daylight creating a higher level of illumination than would be provided solely by the provided light fixtures.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life.

(102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2015

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ruzica Subotic-Howell

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