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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 11, 2013 | 2013_179103_0065 | O-000376-13, O-000385-13 | Critical Incident System |

**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**

DARLENE MURPHY (103)

## 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): December 11, 2013**

**During the course of the inspection, the inspector(s) spoke with the Director of Care and the Administrator.**

**During the course of the inspection, the inspector(s) reviewed resident health care records and the home's policy on lifts and transfer procedures.**

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

## Falls Prevention

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10 s. 8 (1) in that the home did not comply with the requirements under O. Reg 79/10 s. 49 (1) related to lifts and transfers of residents.

On an identified date, Resident #1 fell in the tub room and sustained injuries. The home investigated the incident and determined the Personal support worker had completed the resident bath and instructed the resident to stand at the side of the tub while the staff member left the room to dispose of the dirty linens.

Resident #1's care plan, at the time of this incident, indicated the resident required a two person physical assist for bathing. The home's policy, "Safety-Mandatory lift and Transfer Procedures, CS-6.2", indicates under "Procedure", that two employees must be present before the lift/transfer commences and until the resident is safely in the bath tub, his/her chair, wheelchair or bed.

Staff failed to comply with the home's policy on lift and transfers. [s. 8. (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 Resident #1's plan of care is followed to ensure two staff provide physical assistance for bathing in accordance with the home policy, to be implemented voluntarily.***

**Issued on this 11th day of December, 2013**

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