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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Dec 23, 2015	2015_328571_0016	033592-15	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

PATRICIA MATA (571), CHANTAL LAFRENIERE (194), KARYN WOOD (601), MEGAN MACPHAIL (551)

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): December 7, 8, 9, 10, 11, 14, 15, 16, 17, and 18, 2015.

The following logs were inspected during the Resident Quality Inspection (RQI): Complaint logs #004840-14 and #025871-15 related to staffing, complaint log #000643-15 related to misappropriation of funds, complaint log #025230-15 related to temperature of the home, critical incident logs #006793-14, #010790-15, #016109-15, and #015879-15 related to abuse, critical incident logs #002059-15 and #034214-15 related to falls, critical incident log #006992-15 related to missing resident.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSW), Life Enrichment Coordinator (LEC), RAI Coordinator, Office Manager, Dietitian, Residents, Family Members, President of Family Council and President of Resident Council. In addition, the inspectors conducted a tour of the resident home areas, reviewed residents health care records, identified home policies and procedures, licensee's internal investigations related to critical incidents and complaints, staff schedules, posted menus, Resident Council and Family Council minutes. Observed medication administration processes, infection control processes, and meal service.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

2 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	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 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. Critical Incident Log #006992-15:

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #020 as specified in the plan.

Resident #020 was admitted to the home on a specified date. Resident #020's care plan indicated that every fifteen minute checks were required due to resident #020's attempts to exit the home since admission.

Review of resident #020's progress notes indicated that on a specified date, RN #112 received a call from a nearby nursing home indicating that resident #020 had been found outside by a stranger and brought to the nearby nursing home by car. During an interview, PSW #111 indicated that resident #020 was last seen in the home by the front door, on a specified and time. The Administrator indicated that the resident was able to exit the building when visitors were exiting.

Review of resident #020's "Fifteen Minute Resident Check" documentation on a specific date indicated that the every fifteen minute checks had not been documented by PSW #107. According to the Director of Care, PSW #107 was responsible for completing the every fifteen minute safety checks for resident #020 and it was identified that the safety checks had not been completed for resident #020 on that date over a 40 minute period when resident #020 had exited the home.

Care set out in the plan of care for resident #020 was not provided as specified related to

the completion of every fifteen minute safety checks as directed in resident #020's plan of care. [s. 6. (7)]

2. Critical Incident Log #010790-15:

The licensee failed to comply with LTCHA, 2007 s. 6(7) when the plan of care for Resident #44 was not provided as set out in the plan related to sleep and rest.

Resident #44 brought forward a complaint to the home on a specified date related to a request for care being refused by RN #121 on specific date and time.

The Administrator investigated the complaint immediately and determined through interviews with the identified staff, PSW #122, #123 and RN #121 that care needs had not be provided to the resident as requested.

On a specified date, resident #044 requested to get out of bed at a specific time. PSW #122 and #123 indicated in their statements to the Administrator that the resident had been instructed that he/she could not be assisted out of bed because they did not have any clean slings. After further investigation, the Administrator determined that clean slings were available for transfer.

On a separate date, resident #044 requested to get out of bed. RN #121 indicated in his/her statement to the Administrator that he/she asked Resident #044 to wait for the next shift. The resident refused to wait and was only assisted out of bed by staff when the resident indicated they would get out of bed on their own if they did not assist him/her.

The plan of care for resident #044 at the time of the incident directs under sleep and rest:
-the resident has restless nights. The resident will wake at different times and will ask staff to get him/her out of bed when the resident does not want to be in bed any longer.

Care set out in the plan of care for resident #044 was not provided as specified in the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that different approaches had been considered and the plan of care revised after resident #031 fell.

A review of the clinical records indicated that resident #031 fell on a specific date. At the

time of the fall, the resident had a bed alarm that sounded to alert staff the resident had gotten out of bed. However, staff found the resident lying on the ground. No injury was sustained. On another date, resident #031 had another fall without injury. The documentation indicates the alarm was not functioning.

In an interview, RN #113 indicated that the alarm was working but was not very loud therefore could not be heard at the nursing station.

In a separate interview, the DOC indicated that after resident #031 fell on the second date, he/she had the maintenance employee turn up the volume of the alarm. The DOC tested the alarm to ensure it was functioning but indicated that staff would still not be able to hear the alarm from the nursing station. No other immediate interventions were put in place to prevent falls or injury from falls after either fall.

Inspector #571 observed that the bed alarm can not be heard from the nursing station when activated.

Therefore, the licensee failed to consider different approaches in the revision of resident #031's plan of care after two falls. [s. 6. (11) (b)]

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 care set out in the plan of care is provided to residents and when a resident's plan of care is reassessed and revised, that different approaches are considered, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident’s health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #031 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when the resident experienced significant weight changes.

Resident #031’s weight declined 5% (3.3kg) over a specified month. A review of the resident’s health record and an interview with the Registered Dietitian (RD) indicate that the weight change was not assessed.

Resident #031’s weight declined - 5% (3.1kg) in another month. In the coding of the MDS assessment for that time period, significant weight loss was noted. In the written assessment completed by the RD, the RD noted that an oral supplement which the resident had previously enjoyed would be tried. In an interview with the Registered Dietitian (RD) she indicated that an oral supplement was not tried as an appetite stimulant was ordered. According to the information provided from the RD, a medication was ordered. A review of the resident’s health care record shows that on that date, the drug was in fact reduced from 30mg once per day to 15mg once per day and resident #031 had actually been on 30mg of the drug since at six months. Therefore, the drug was not a new intervention and no other action was taken to address resident #031’s weight loss.

Following the weight loss of 5% (3.1kg) over a specified month, resident #031’s weight declined - 3.9% (2.3kg) the following month.

On a specified date, the RD charted Significant weight change noted. No action was taken, and the RD's note stated No interventions at this time. At this time, Resident #031's weight had declined 9.9% (6.2kg) in three months and 11.8% (7.6kg) in six months.

The resident's weight continued to decline 4.4% (2.5kg) over a specific month and declined 2.6% (1.4kg) between over another month.

A weight supplement was implemented. By this time the resident's weight had declined 16.3% (10.3kg) in six months. The outcome of implementing Resource 2.0 at that time was evaluated three months later when the RD charted that the resident had lost 5.3kg in the past quarter. No further action was taken to address Resident #031's weight which continued to decline.

Since implementing weight supplement, resident #031's weight has further declined 12.5% (6.6kg). In an interview with the RD, she stated that no other actions have been tried or taken since the weight supplement was started despite the continued weight loss.

To summarize, resident #031 had a weight loss of 14.8% (8kg) in six months and 30.4% (20.2kg) in the past year.

The RD stated that these weight changes have not been assessed as of this time.

Therefore, the licensee failed to ensure that resident #031 was assessed and appropriate action taken and outcomes evaluated after resident #031 experienced weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents experiencing weight loss as per the regulations, are assessed and appropriate action taken and outcomes evaluated, to be implemented voluntarily.

Issued on this 23rd day of December, 2015

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

Original report signed by the inspector.