Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
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Public Report

Report Issue Date: February 19, 2025

Inspection Number: 2025-1202-0001

Inspection Type:
Critical Incident
Follow up

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

Long Term Care Home and City: Frost Manor, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 3 to 7, 10 to 12, and 14, 2025.
The inspection occurred offsite on the following date(s): February 13, 2025.
The following intake(s) were inspected:
• Intake: #00129587 - related to resident-to-resident physical abuse resulting in injury.
• Intake: #00130098 - related to resident-to-resident physical abuse.
• Intake: #00131493 - Follow-up #1 - CO #004 - Infection prevention and control program (IPAC), CDD 12/30/2024.
• Intake: #00131494 - Follow-up #1 - CO #003 - IPAC program, CDD 12/30/2024.
• Intake: #00131495 - Follow-up #1 - CO #002 - Food Production, CDD 12/30/2024.
• Intake: #00131496 - Follow-up #1 - CO #001 - Compliance with manufacturers' instructions, CDD 12/30/2024.
• Intake: #00132635 - related to resident-to-resident physical abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #004 - Inspection #2024-1202-0001 related to O. Reg. 246/22, s. 102 (7) 6.
Order #003 - Inspection #2024-1202-0001 related to O. Reg. 246/22, s. 102 (2) (b)
Order #002 - Inspection #2024-1202-0001 related to O. Reg. 246/22, s. 78 (7) (a)
Order #001 - Inspection #2024-1202-0001 related to O. Reg. 246/22, s. 26

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care Plans and Plans of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (1)
24-hour admission care plan
s. 27 (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 246/22, s. 27 (1).

The licensee failed to ensure that a 24-hour admission care plan was developed for a resident and communicated to direct care staff within 24 hours of the resident's admission to the home. Staff documented multiple incidents of responsive behaviour and near misses in the days leading up to the first critical incident of

physical abuse with another resident on the sixth day after admission. The initial 24-hour care plan was opened one week after the resident was admitted and was left blank. The former Administrator confirmed that a 24-hour care plan had not been developed.

Sources: resident clinical records, former Administrator interview.

WRITTEN NOTIFICATION: Care Plans and Plans of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (9) (a)
24-hour admission care plan
s. 27 (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change;

The licensee failed to ensure that a resident was reassessed and the care plan was reviewed and revised when their care needs changed. Near misses and ongoing responsive behaviour continued, culminating in multiple critical incident reports. Behaviour related care plan revisions were not made until 3 and 11 days respectively, after the first two critical incidents.

The Behavioural Supports Ontario (BSO) Lead received an email from the Administrator eight days after the second incident, directing them to focus on updating the behavioural section of the care plan.

Sources: three critical incident reports, Administrator email to BSO Lead, resident clinical records, former Administer interview.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that when a resident was exhibiting altered skin integrity, they were reassessed at least weekly by an authorized person, if clinically indicated. The former Skin and Wound Lead confirmed that there was a weekly skin assessment missed for a resident, prior to the resolution of the altered skin integrity on a specified date.

Sources: resident clinical records, interview with former Skin and Wound Lead.

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions after critical incidents involving a resident occurred on three separate specified dates.

A behaviour trigger and intervention were identified by registered nursing staff in progress notes but were not listed in the care plan or in clipboard reference documents used by staff who were monitoring the resident. Observations on the Behavioural Supports Ontario-Dementia Observation System (BSO-DOS) tool for the resident, were started late and incomplete for the admission assessment and after

the first critical incident. The resident was still within the five-day monitoring window after the first critical incident, when the BSO-DOS tool was left blank for several hours at the time of the second critical incident. The Director of Care (DOC) confirmed that a behaviour intervention related to monitoring was not in place during a specific activity, on a specified date.

Sources: observations, resident clinical records, staff clipboard reference documents, DOC and former Administrator interviews.

WRITTEN NOTIFICATION: Construction, Renovation, etc., of Homes

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

The license failed to receive approval from the Director, to alter a resident space of the home into a storage and intermittent workspace. The Director of Care (DOC) and Acting Administrator confirmed that the room was intended to be an end-of-life palliative room, but residents preferred to stay in their own rooms, so they were temporarily using it for storage and occasionally for activities like swabbing or mask fit testing.

Sources: observation, DOC and Acting Administrator interviews.