



**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 prévue le Loi de 2007 les foyers de soins de longue**

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 25, May 4, 7, 8, 2012	2012_046166_0018	Critical Incident

**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**

CAROLINE TOMPKINS (166)

**Inspection Summary/Résumé de l'inspection**

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

During the course of the inspection, the inspector(s) spoke with the Administrator, a member of the Registered staff and a Personal Support Worker.

During the course of the inspection, the inspector(s) observed the resident, reviewed the resident's clinical health records and reviewed the home's policies and procedures related to pain and lifts and transfers

The following Inspection Protocols were used during this inspection:

Pain

Personal Support Services

Findings of Non-Compliance were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.)</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: 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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

2. Every resident has the right to be protected from abuse.

3. Every resident has the right not to be neglected by the licensee or staff.

→ 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

5. Every resident has the right to live in a safe and clean environment.

6. Every resident has the right to exercise the rights of a citizen.

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

9. Every resident has the right to have his or her participation in decision-making respected.

10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, 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,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

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**Findings/Faits saillants :**

1. The resident sustained an injury related to a fall from a lift. The resident was given a PRN analgesic X1 for pain on the eve of the injury. The resident is aphasic and unable to verbally express any discomfort. There is no evidence to establish that the resident was assessed for any further discomfort until 4 days after the fall when it was noted that the resident's hand and arm were swollen. The resident was sent to the hospital for further examination. Clinical documentation notes that 5 days post injury a pain assessment and evaluation tool was used to assess the resident's pain and then the resident started to receive an analgesic on a regular basis.[s.3.(1)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 every resident has the right to be properly cared for in a manner consistent with his or her needs., to be implemented voluntarily.*

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**WN #2:** 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 subsections:

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  
(b) is complied with. O. Reg. 79/10, s. 8 (1).

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**Findings/Faits saillants :**

1. The home's pain policy #CS-12.31, states :

A pain assessment (side A) shall be completed:when there is a significant change in the resident's status and pain control may be a concern.

A pain assessment tool shall be initiated each time a pain assessment is completed as a result of a significant change in a resident's status and maintained until optimal pain control is achieved:

The resident's injury occurred on February 10/12 it was not until February 15/12 that the pain assessment and evaluation tool was initiated.

Clinical documentation notes that injuries were evident to the resident's right arm,elbow and hand from the date of the injury until the assessment tool was initiated five days post injury.

**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 ensure that where the Act or this Regulation requires the licensee of a long term-care home to have, institute or otherwise put into place any plan or policy the licensee is required to ensure that the plan or policy is complied with., to be implemented voluntarily.*

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

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**Findings/Faits saillants :**

1. The resident requires the assistance of a mechanical lift to transfer.  
The home's policy states that two staff are to be present while transferring a resident.  
In this case the staff were not at the resident's side while the resident was still in the lift/sling. The clinical documentation states, "the staffs' backs were turned" and at that time the resident "tried to get out and fell" sustaining an injury.

**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 staff use safe transferring and positioning devices or techniques when assisting residents., to be implemented voluntarily.*

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**WN #4: 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 subsections:**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**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).**

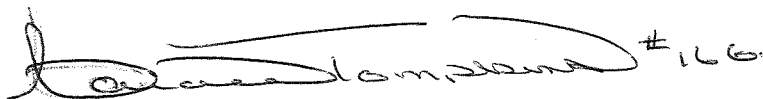
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**Findings/Faits saillants :**

1. The resident's plan of care identifies that the resident is totally dependent and requires a mechanical lift for transfers and "two staff required at all times when transferring" At the time of the fall the two staff were not at the resident's side while she was still in the mechanical lift/sling.  
2. The critical incident occurred on February 10/12. Clinical documentation establishes that the resident's Power of Attorney was not notified of the fall until February 14/12.

Issued on this 8th day of May, 2012

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

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