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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Aug 11, 2016	2016_291194_0016	011188-16, 013057-16	Complaint

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 25, 26, 27 and August 04, 05, 2016

Also inspected was Log #000268-16 Critical Incident, alleged staff to resident emotional abuse, Log #007115-16 Critical Incident, alleged staff to resident verbal abuse, Log #011188-16 Complaint, related to provision of care and Log #013057-16 complaint, related to Housekeeping.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Physio Therapist (PT)and Physio Therapist Assistant (PTA)

The inspector also observed the provision of staff to resident care, resident home and common areas, reviewed licensee's internal abuse investigation, abuse policy, staff educational records, clinical health records of identified residents, housekeeping records and practices.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home is forwarded to the Director

Log #011188-16 related to resident #001

Resident #001 is wheelchair dependent requiring assistance with all mobility , requiring extensive assistance with all transfers, and activities of daily living(ADL). Resident #001 is cognitively well.

During the course of the inspection the clinical health record for resident #001 was reviewed. Along with the clinical health record the inspector reviewed a number of letters provided to the home by resident #001. Three of the letters reviewed indicated concerns with the provision of care.

The Director of care received a three letters over a four month period. One letter was related to concerns with the mobility equipment,the second and third letters were related to provision of care.

Interview with DOC/Administrator was conducted on July 27, 2016 to determine if the letters identified were forwarded to the Director. Administrator/DOC indicated that resident #001 preferred to communicate in writing and the home did not feel that the letters were complaints, but a way of communicating to the home. Administrator/DOC have indicated to the inspector that the identified letters were not forwarded to the Director [s. 22. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home:
* been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
* where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately

Log #011188-16 related to resident #001

Resident #001 is wheelchair dependent requiring assistance with all mobility , requiring extensive assistance with all transfers, and activities of daily living(ADL). Resident #001 is cognitively well.

During the course of the inspection the clinical health record for resident #001 was reviewed. Along with the clinical health record the inspector reviewed a number of letters provided to the home by resident #001. Three of the letters reviewed indicated concerns with the provision of care.

The Director of care received a three letters over a four month period. One letter was related to concerns with the mobility equipment,the second and third letters were related to provision of care.

Interview with DOC/Administrator was conducted on July 27, 2016 to determine if a response had been provided to resident #001. Administrator/DOC indicated that the resident #001 preferred to communicate in writing and the home did not feel that her letters were of a complaint nature, but a way of communicating to the home. Administrator/DOC have indicated that the identified letters were investigated but a response to resident #001 was not provided [s. 101. (1) 1.]

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Issued on this 18th day of August, 2016

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

Original report signed by the inspector.