Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministére 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 June 10 2011 | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jun 15, 16, Jul 4, 2011 | 2011_034117_0011 | 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**

LYNE DUCHESNE (117)

## 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 via telephone interview on June 10 2011.**

**During the course of the inspection, the inspector(s) reviewed the Critical Incident report # 2703-000004-11 submitted on June 10 2011.**

**The following Inspection Protocols were used in part or in whole during this inspection:**

**Critical Incident Response**

**Safe and Secure Home**

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

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Definitions | Définitions |
|---|---|
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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. 107. Reports re critical incidents**

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

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**

**1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.**
**2. An unexpected or sudden death, including a death resulting from an accident or suicide.**
**3. A resident who is missing for three hours or more.**
**4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.**
**5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.**
**6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

**s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).**

**Findings/Faits sayants :**

1. On June 8, 2011 at 20:15, the home lost hydro power. Hydro power was restored June 9, 00:15. The home was without power for 4 hours.

2. The home notified the MOHLTC of their loss of essential services via an electronic Critical Incident report submitted on June 10 2011, 36 hours after the loss of essential services.

3. The home failed to notify the MOHLTC immediately about their loss of essential services on June 8, 2011 that occurred after normal business hours. The Licensee did not make the report using the Ministry's method for after hours emergency contact.

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators**

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

**s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).**

**Findings/Faits sayants :**

1. Jun 16, 2011 - 15:40 - O.Reg. 79/10 sect 19 (2) applies to this home because the home has beds that have been identified by the Ministry as structural category "C" beds .

As per O.Reg. 79/10 sect 19 (4), section (1) (a-b-c) is applicable as the home has Class C bed and therefore must have guaranteed access to a generator that will be operational within 3 hours of a power outage and that can maintain (section 1 a) the heating system, (section 1 b) the emergency lighting in hallways, corridors, stairways and exits, and (section 1 c) essential services, including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support, safety and emergency equipment.

2. On June 8, 2011 at 20:15, the home lost hydro power. Hydro power was restored June 9, 00:15. The home was without power for 4 hours.

3. On June 10, 2011, the home notified the MOHLTC, via a critical incident report, that they do not have a generator on site and did not have an operational generator within 3 hours of the power outage.

4. Telephone call held on June 10, 2011 with Administrator Connie Daly confirmed that the home has no generator and did not have an operational generator within 3 hours of the power outage.

**Issued on this 4th day of July, 2011**

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