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 prévue 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 soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 15, 2019	2019_643111_0011	007456-19	Critical Incident System

Licensee/Titulaire de permis

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

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 8, 2019

A critical incident report (CIR) was inspected related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Admin/DOC), Personal Support Workers (PSW) and RAI Coordinator.

During the course of the inspection, the inspector: observed a resident's room, reviewed a resident's health record, the home's investigation and reviewed job descriptions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

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

1 WN(s)
1 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	Légende 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure there is an organized program of nursing services for the home to meet the assessed needs of the residents and an organized program of personal support services for the home to meet the assessed needs of the residents.

The organized program of nursing and personal support services for the home included the following job descriptions:

Review of the job description for "[specified shift] Registered Staff"(revised August 2018) indicated:
-at a specified time, complete narcotic count and read communication book.
-at a specified time, receive report with PSWs.
-at a specified time, do rounds to ensure that all residents are accounted for and that there are no safety concerns.

Review of the job description for "Personal Support Worker, shift [specified] (revised July 2018) indicated:
-at a specified time, attend report, do a room to room visual resident check or change, ensuring all residents are accounted for.
-at a specified time, do first resident rounds, toilet residents as per toileting plan, check residents for incontinence, change and provide peri-care, reposition.

Related to Log # 007456-19:

A critical incident report (CIR) was submitted to the Director on a specified date, for an unexpected death. The CIR indicated on a specified date and time, resident #001 was found deceased.The CIR was completed by the Administrator/DOC.

During an interview with the Administrator/DOC, the Administrator/DOC (Admin/DOC) indicated resident #001 had no prior history of specified diagnosis or prior history of specified responsive behaviours and was independent with their care. The Admin/DOC indicated resident #001 was seen on a specified date and time, by RN #100. The Admin/DOC indicated on a specified date, RN #101, PSW #102 and #103 were working the specified shift and had not completed a full check on all the residents, after receiving report until a specified time, when PSW #103 went into resident #001's room and suspected the resident had sustained a fall. The PSW went to get the RN for assistance. The Admin/DOC indicated PSW #102 then entered the bathroom and found the resident deceased in a specified area. The Admin/DOC indicated the police, 911 and the coroner were all notified of the death. The Admin/DOC indicated after they had interviewed all the staff, they had confirmed that the specified shift had not checked on resident #001 for a specified period of time, despite the staff routine indicating that all residents were to be checked on after they received report. The Administrator/DOC expressed concerns that the RN (and the PSWs) failed to account for all of their residents, after receiving report at the start of their shift, as required.

Review of the health care record for resident #001 indicated the resident had no prior specified diagnosis and had no previous concerns with specified responsive behaviours.

Review of the current written care plan for resident #001 indicated the resident only required minimal assistance with personal care.

Review of resident #001 progress notes for a specified three month period, indicated the resident had no prior history of a specified diagnosis or responsive behaviour. There was no documentation completed the day before the resident was found deceased. A late entry was completed two days later, indicating the resident was given specified medications for complaints of pain and nausea at a specified time. The following day, at a specified time, RN #101 was notified by a PSW that the resident was found in a specified area deceased.

Review of the home's investigation indicated the two PSWs (#102 and #103) who worked on the specified date and shift, did not account for all of the residents at the start of the shift, after receiving report. RN #101 who also worked on the specified date and shift, did not account for all of the residents after receiving report, at the start of their shift and resident #001 was not unaccounted for, approximately three hours, when the resident was found in a specified area, deceased.

The licensee failed to ensure that the organized program of nursing services and personal support services for the home, to met the assessed needs of the residents.

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 organized program of nursing services for the home to met the assessed needs of the residents and an organized program of personal support services for the home to met the assessed needs of the residents, to be implemented voluntarily.

Issued on this 16th day of April, 2019

[redacted]

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

Original report signed by the inspector.