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 Service Area Office
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: October 18, 2022
Inspection Number: 2022-1202-0001
Inspection Type: Critical Incident System
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partn
Long Term Care Home and City: Frost Manor, Lindsay

Lead Inspector	**Inspector Digital Signature**
Catherine Ochnik (704957)	Catherine Ochnik Digitally signed by Catherine Ochnik Date: 2022.10.25 10:47:24 -04'00'

Additional Inspector(s)
Carole Ma (741725)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 3, 4, 5, 6, 2022.

The following intake(s) were inspected:

- Intake: #00004737- related to an unexpected death of a resident.
- Intake: #00005245- related to staff to resident abuse and neglect.

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

Falls Prevention and Management
Resident Care and Support Services
Reporting and Complaints
Infection Prevention and Control
Prevention of Abuse and Neglect

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INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021 *s. 24 (1)*

The licensee has failed to ensure that residents of the home are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director indicating that in a written statement to the home's Director of Care (DOC) and Administrator, a staff member stated they witnessed Personal Support Worker (PSW) #111 pushing a resident in a wheelchair. The staff member noticed that the resident's feet were underneath the wheelchair footrest pad, and that the resident was screaming. The staff member called out to PSW #111 to have them stop and prevent a possible injury. PSW #111 continued to push the wheelchair and then left. During an interview, the staff member confirmed the details of this incident.

The incident was also witnessed by PSW #120. PSW #120 confirmed they observed the resident's feet behind the padding of the footrests while being pushed in the wheelchair.

The licensee's internal investigation indicated the Administrator concluded the allegation was founded, that PSW #111's actions placed the resident at risk for a critical injury. The DOC stated in an interview that the home determined that staff to resident physical abuse and neglect had occurred.

The licensee failed to protect the resident from abuse and neglect when PSW #111 was observed pushing the resident while their feet were not in a safe position and continuing to push the resident after being alerted. This resulted in the resident experiencing pain and placed them at risk for injury.

Sources: CIR, interviews with staff and DOC, review of licensee's internal investigation.

[741725]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021 *s. 28(1)2*

The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Rationale and Summary

A CIR indicated that an alleged incident of staff to resident abuse and neglect occurred but was not reported to the Director immediately.

The CIR indicated that a staff member sent an email to the DOC and Administrator, detailing that they witnessed an incident of staff to resident abuse and neglect. The staff member acknowledged in an interview with the inspector that they should have immediately reported the incident to the charge nurse or DOC.

According to the home's "Zero Tolerance of Abuse and Neglect of Residents" policy (updated March 30, 2022), abuse or neglect of a resident by staff that resulted in a risk of harm to the resident is required to be immediately reported to the Director.

Sources: CIR, Zero Tolerance of Abuse and Neglect of Residents (updated March 30, 2022), interview with staff.

[741725]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22 s. 115 (1) 2

The licensee has failed to 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 (5): An unexpected or sudden death, including a death resulting from an accident or suicide.

Rationale and Summary

A resident unexpectedly passed away after an unresponsive episode. A CIR for the unexpected death of the resident was submitted to the Ministry of LTC the following day. In an interview, the DOC acknowledged that the CIR for the unexpected death of the resident was not reported to the Ministry of LTC immediately.

Sources:
CIR, resident health records and interview with DOC.

[704957]

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