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

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Original Public Report

Report Issue Date: October 31, 2023
Inspection Number: 2023-1202-0003
Inspection Type: Proactive Compliance Inspection
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: Frost Manor, Lindsay

Lead Inspector	**Inspector Digital Signature**
Patricia Mata (571)	Patricia Mata Digitally signed by Patricia Mata DN: cn=Patricia Mata, o=Ministry of Long Term Care, ou, email=patricia.mata@ontario.ca, c=CA Date: 2023.11.03 12:52:22 -04'00'

Additional Inspector(s)
Diane Brown (110)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 11-13, 16-20, 2023

The following intake(s) were inspected:

- Intake: #00095848 -Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee failed to ensure that the home was safe and secure.

Summary and Rationale

During a tour of the home, a key on a chain was observed hanging outside of one mop room so that staff could access the room. The room contained peroxide disinfectant and cleaning solution.

The Administrator was informed by Inspector #571; the key was removed.

The licensee put residents at risk of harm from exposure to harmful chemicals.

Sources: Observations and interview with the Administrator. [571]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure the care set out in the plan of care was provided to residents #007 and #008 as specified in the plan.

Summary and Rationale

1. During the Proactive Compliance Inspection (PCI), meal service was inspected. Resident #007 was observed with the incorrect modified diet related to texture and consistency. An inappropriate assistive eating/drinking device had also been provided.

The resident's nutritional profile, dietary information available at the point of meal service, identified the resident at high nutritional risk, requiring a modified textured and consistency diet without the use of the specified eating/drinking device.

RPN #105 and cook/dietary aide #109 confirmed the resident did not receive their meal as per their nutritional profile. The Registered Dietitian confirmed the risks associated with not providing safe textured food and fluid consistencies and the use of inappropriate assistive devices for resident #007 who was at risk of aspiration.

The failure to follow the care set out in resident #007's nutritional profile placed the resident at risk of unsafe swallowing.

Sources: observations, nutritional profiles, and interviews (RPN #105, cook/dietary aide #109, Registered Dietitian). [110]

Summary and Rationale

2. During the PCI, meal service was inspected. Resident #008 was observed with the incorrect modified diet related to texture. An inappropriate assistive eating/drinking device had also been provided.

The resident's nutritional profile, dietary information available at the point of meal service, identified the resident at high nutritional risk, requiring a modified textured diet without the use of the specified eating/drinking device.

RPN #105 confirmed the resident did not receive their meal as per their nutritional profile. The Registered Dietitian confirmed the risks associated with not providing resident #008 with safe textured food and eating/drinking devices.

The failure to follow the care set out in resident #008's nutritional profile placed the resident at risk of unsafe swallowing.

Sources: observations, nutritional profiles, and interviews (RPN #105, Registered Dietitian). [110]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)

The licensee failed to ensure at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Summary and Rationale

An interview with the Director of Care confirmed a resident survey was not completed in 2022. The DOC stated the last 'Resident Experience Survey' was completed in 2021.

When the licensee failed to conduct an annual resident, family, and caregiver survey, this was a missed opportunity for input into the operation of the home and client satisfaction for quality improvement.

Sources: interview with Director of Care and the home's Resident Experience Survey from 2021. [110]

WRITTEN NOTIFICATION: Orientation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 11.

The licensee failed to ensure that staff of the home received training in the area of Falls Prevention and Management and Pain Management including pain recognition of specific and non-specific signs of pain prior to performing their responsibilities.

Summary and Rationale

As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the Long-Term Care Home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home. Furthermore, "staff", in relation to a Long-Term Care Home, means persons who work at the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

While conducting a proactive compliance inspection (PCI), the Inspector reviewed the home's training records in Surge Learning for each staff identified as working on time schedule of September 22, 2023-October 5, 2023. Agency staff RNs #101 and #100 had not completed the required training on Falls Prevention and Management and RN #100 had also not completed training on Pain Management including pain recognition of specific and non-specific signs of pain.

In an interview, the DOC confirmed agency RN #100 and RN #101 had not completed the required training.

When the licensee failed to ensure all staff of the home received training related to Falls Prevention and Pain Management, the home's best practices may not have been followed and negatively impacting residents with pain.

Sources: Surge Learning, Staff Schedule and interview with the DOC. [110]

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)

The licensee failed to ensure that the interdisciplinary program for pain was developed and implemented in the home and provided for assessment instruments.

Summary and Rationale

The home's pain management program, including a policy for Pain Assessment, referenced the Pain Assessment in Advanced Dementia (PAINAD) scale as the assessment of choice. A pain assessment for cognitively intact residents was not included in the policy.

An interview with RN #106 indicated the home currently has only one pain assessment tool, PAINAD, and confirmed, when asked, that it was not relevant when assessing cognitively intact residents with pain.

The RNAO's best practice guideline "Assessment and Management of Pain in the Elderly", Self-directed learning package for nurses in long-term care, dated May 2007, states "Self-report is the 'gold standard' and primary source of assessment for the verbal, cognitively intact resident. Because self-report is the most reliable indicator of pain, every effort should be made to speak with residents/families/caregivers about their pain, ache, or discomfort. Recent research has shown that even individuals with significant cognitive impairment may be able to use a pain rating scale (Ferrelle, Ferrelle, River, 1995). Findings from this study suggest that self-report and using a pain rating scale can be best accomplished by allowing sufficient time for the resident to process the information and then respond.

A review of the Pain Assessment policy fails to direct the assessment of pain in a resident cognitively intact.

The DOC confirmed that registered staff were instructed to follow the PAINAD assessment and assess for a numerically pain score for cognitively intact resident's with pain. The policy fails to direct this approach.

When the licensee failed to ensure that the homes pain management program included a pain assessment for residents who were cognitively intact, this placed residents at risk of not being allowed to express their needs based on a true reflection of their perceived pain.

Sources: the licensee's Pain Assessment policy, RNAO's best practice guideline "Assessment and Management of Pain in the Elderly", Self-directed learning package for nurses in long-term care, dated May 2007 and interviews (RN #106 and DOC). [110]

WRITTEN NOTIFICATION: Menu planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee failed to ensure that the planned menu items were offered and available at lunch on October 11, 2023.

Summary and Rationale

The homes' policy entitled 'Menus' stated the beverages, as a minimum, to be offered to each resident daily for a total of 2160mls/day. The beverages at lunch included 180mls of milk. The home's posted menu also identified 180 ml milk to be offered at each meal.

During the PCI, meal service was inspected. On October 11, 2023, lunch was observed in the large dining room. Residents were not observed having been served or offered milk. RPN #105, monitoring the dining room confirmed the lack of milk served. Residents #007 and #008 were not offered milk and a review of their food/fluid preferences did not identify milk as a dislike. An interview with the Life Enrichment Aide #102, who served the beverages to residents, revealed an unawareness of the home's requirement to offer milk at meals.

Separate interviews with the Nutritional Care Manager and RD revealed that milk should be offered to all residents unless otherwise documented.

Failure to offer milk at meals negatively impacts the nutrition value of meals, enjoyment and may compromise the total amount of fluids offered to each resident each day.

Sources: observations, week three regular menu at a glance, home's policy entitled 'Menus', and interviews (RPN #105, Life Enrichment Aide #102, Nutritional Care Manager and RD). [110]

WRITTEN NOTIFICATION: Food production

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (c)

The food production system must, at a minimum, provide for standardized recipes for all menus.

Summary and Rationale

During the PCI, meal service was inspected. On October 11, 2023, lunch was observed in the large dining room. PSW #110 was observed portioning soup that was referred to as 'minced-pureed' beef noodle soup. The soup was lumpy with minced pieces of food and had the appearance of a minced soup. The

Inspector confirmed with RPN #105 that the soup was of a minced consistency. The soup had been served to at least two residents that required pureed consistency diets.

In an interview, cook #104 shared they used an immersion tool to puree the soup and not the robot coupe because of the hot nature of the food. Inspector requested the recipe for the preparation of the pureed beef noodle soup. The recipe failed to include the methodology. The recipe stated, “puree product to desired consistency”. Cook #104 confirmed that directions or the methodology in the recipe were lacking. The cook shared they were unsure how to describe a desired pureed consistency but agreed the pureed beef noodle soup prepared at lunch was consistent with a minced texture.

The Dietitians of Canada Best Practices for Nutrition, Service and Dining in Long Term Care Homes, A Working Paper of the Ontario LTC Action Group 2019 stated standardized recipes are used to prepare all food and beverages for all textures and fluid consistencies and include the method or procedure for combining ingredients.

A standardized recipe when followed yields a desirable and safe consistency.

An interview with the NCM confirmed that pureed recipes were not standardized as part of the food production system.

When standardized recipes were not used the consistency of the textured modified product would not be standardized, with a further risk to a compromised nutrient value and density of the final product.

Sources: observations, recipe for pureed beef noodle soup, The Dietitians of Canada Best Practices for Nutrition, Service and Dining in Long Term Care Homes, A Working Paper of the Ontario LTC Action Group 2019 and interviews (PSW #110, RPN #105, Cook #104, Nutrition Care Manager). [110]

WRITTEN NOTIFICATION: Food production

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)

The licensee failed to ensure the food production system must, at a minimum, provide for the preparation of all menu items according to the planned menu.

Summary and Rationale

The home’s regular textured menu, was posted on a sheet titled 'week three regular menu at a glance' in the dining room, along with a menu for therapeutic and texture-modified menus. For lunch on Wednesday October 11, 2023, the regular menu stated a bacon, lettuce, and tomato (BLT) sandwich, bean salad or salmon bites and creamy cucumber salad. The minced menu stated minced pork roast on wheat along with minced bean salad and salmon bites with minced cucumber salad while the pureed

menu stated pureed pork roast on wheat along with pureed bean salad and pureed salmon salad on wheat along with pureed Prince Edward vegetables.

A review of the home's food production sheets directed the preparation of the regular, minced, and pureed items according to the planned menus.

During the PCI, meal service was inspected. On October 11, 2023, lunch was observed in the large dining room. The residents on minced and pureed textured diets were not provided with texture modified pork roast but a BLT sandwich that was both minced and pureed. The second choice for those on pureed diets was not pureed salmon salad as planned. Pureed Prince Edward vegetables were not prepared.

An interview with Cook/Dietary Aide #104 stated they only referred to the 'regular menu at a glance' and not the minced and pureed menus sharing that was how they were trained over 3 years ago. An interview with the registered dietitian (RD) revealed the staff were expected to follow the planned menus for minced and pureed to ensure adequate nutrition and an appropriate texture. Currently 53% of the residents receive a form of nutritional supplement are small eaters and the nutrient density of the menu is important.

Failing to prepare and serve the minced and pureed menus as planned and approved by the RD may negatively impact the nutritional value and palatability of meals.

Sources: Observations, 'week three regular menu at a glance', therapeutic and texture modified menus, food production sheets and interviews with Cook/Dietary Aide #104 and RD. [110]

WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee failed to ensure food was being served at a temperature that is both safe and palatable to the residents.

Summary and Rationale

During the PCI, meal service was inspected. On October 11, 2023, at lunch resident #007 was still eating their soup when their hot entrée was served. The entrée was placed out of reach of the resident while they continued to eat their soup. Fourteen minutes later the temperature of the entrée was measured by cook/dietary aid #109 at the inspectors request; the temperature was 118-degrees Fahrenheit. The entrée continued to sit another 13 minutes before being served to the resident. A review of the home's policy entitled "Pleasurable Dining" required all meals to be served to residents at safe, appropriate temperatures.

The Nutritional Care Manager indicated the temperature of hot food should be served at approximately 175-degrees Fahrenheit and the temperature of resident #007's entrée at the time of consumption was not appropriate.

Failure to provide a modified texture meal at a palatable hot temperature may result in less enjoyment of the meal and overall intake.

Sources: observation, "Pleasurable Dining" policy and interviews (cook/dietary aide #109, Nutritional Care Manager. [110]

WRITTEN NOTIFICATION: Housekeeping

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

The licensee failed to ensure they implemented procedures for cleaning and disinfection in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices for contact surfaces.

Summary and Rationale

In an interview, Environmental Services Aide (ESA) #116 confirmed they use Ecolab Peroxide Multi Surface Disinfectant and Cleaner for general cleaning. They indicated they test the strength of the cleaner daily.

The log sheet posted in the mop room ESA staff were using titled "Frost Manor Chemical Check Audit (Peroxide Multi-Surface Disinfectant and Cleaner)" indicated the strength of the cleaner needed to be tested when it was dispensed; the cleaner should test at 3500 parts per million (PPM). If the chemical tests out of range, staff were to report it to management immediately. The cleaner was out of range at 2350 ppm October 16-19, 2023. ESA staff, including ESA #116, had not reported the results to the manager.

The Environmental Service Manager (ESM) indicated that the cleaner should test at 3500 ppm.

Failure to ensure that staff informed management when the strength of the peroxide multi-surface disinfectant and cleaner was testing out of range, increased the risk for infection in the home.

Sources: "Frost Manor Chemical Check Audit (Peroxide Multi-Surface Disinfectant and Cleaner) interviews with ESA #116 and ESM. [571]

WRITTEN NOTIFICATION: Additional training — Direct Care Staff

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee failed to ensure that all staff who provide direct care to residents received annual training provided for in subsection 82 (7) of the Act, specifically, pain management, including pain recognition of specific and non-specific signs of pain.

Summary and Rationale

While conducting a PCI, the Inspector reviewed the home's training records in Surge Learning for each staff identified as working on time schedule dated September 22, 2023- October 5, 2023. PSW's who provide direct care to residents had not been provided 2022 annual training specific to pain including recognition of specific and non-specific signs of pain.

Through an interview with the DOC they confirmed that pain related training had not been provided to PSW's in 2022.

Failure to ensure all PSWs received training in pain recognition of specific and non-specific signs of pain may have left cognitively impaired residents with unnoticed signs of pain.

Sources: Surge Learning, staffing time schedule, interview with DOC. [110]