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 soins de longue durée

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347 Preston St Suite 420
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347 rue Preston bureau 420
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2017	2017_643111_0011	016749-17	Critical Incident System

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

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): July 26 to 28, 2017.

A Critical Incident report related to a missing resident was completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance and the resident.

During the course of the inspection, the inspector reviewed the health record of the resident, observed the residents room and doors/terrace areas, and reviewed the licensee's investigation and doors policy.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
1 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

The licensee failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Related to log # 016749-17:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for a missing resident. The CIR indicated on the same day and at a specified time, resident #001 was noted to be missing from the home.The Resident was last seen in the home approximately four hours earlier and was found approximately eight and a half hours later in hospital with injuries. The CIR indicated a search of the home revealed a door leading to a secured outside area was found unlocked. The resident was unable to recall details of the elopement due to cognitive impairment.

Interview with the Administrator and DOC by Inspector #111, indicated the resident had eloped, as the door leading to a secure outside area was left unlocked. They both indicated the door to the secured outside area was supposed to be locked at a specified time. Interview with the Administrator and DOC later indicated the licensee's written policy which deals with doors leading to secure outside areas had a 'Nightly Door Alarm Test/Doors Locked' tick sheet which was to be completed at a specified time (four hours later than initially identified). The Administrator indicated the policy did not include checking the door leading to the secured outside area.

Review of the licensee's policy indicated only a 'Nightly Door Alarm Test/Doors Locked' tick sheet was available and indicated all exterior doors were to be checked to ensure that the door was locked, but did not indicate when this was to occur. The tick sheet did not include the identified secured outside area.

Interview with resident #001 by Inspector #111 indicated the resident was unable to recall how details of the elopement due to cognitive impairment. The resident was seated in the secured outside area at the time of the interview and indicated she/he frequently sat in the secured outside area.

Telephone interviews with PSW #101 and PSW #102 by Inspector #111, indicated they both worked on the specified date resident #001 eloped. PSW #101 indicated resident #001 was last observed at a specified time and was awake. PSW #101 indicated the resident was not checked on again until four and half hours later and staff noted the resident was missing. The PSW also indicated the door that leads to the secured outside area was unlocked.

Telephone interview with RN #100 by Inspector #111, indicated was working on the

specified date resident #001 eloped, usually completes the checks of all the doors leading to the outside at a specified time, but did not check the door leading to the specified secured outside area. The RN indicated that he/she became aware resident #001 was missing when the two PSW's (PSW #101 & #102) reported the resident missing.

Interview with RPN #106 by Inspector #111 indicated the doors leading to the secured outside area is usually checked by the specified shift nurse. Interview with PSW #104 and RPN #106 indicated resident #001 usually liked to sit in the secured outside area during specified times.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee failed to ensure that the home was a safe and secure environment for the residents as it related to secure outside areas and monitoring of residents.

Related to log # 016749-17:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for a missing resident. The CIR indicated on the same day and at a specified time, resident #001 was noted to be missing from the home.The resident was last seen in the home approximately four hours earlier and was found approximately eight and a half hours later in hospital with injuries. The CIR indicated a search of the home revealed a door leading to a secured outside area was found unlocked. The resident was unable to recall details of the elopement due to cognitive impairment.

Interview with the Administrator and DOC by Inspector #111, indicated resident #001 had no prior history of elopement responsive behaviours prior to this incident.

Telephone interviews with PSW #101 and PSW #102 by Inspector #111, indicated on the specified shift, residents were generally checked approximately twice a shift at specified times (but some residents are checked/assisted more frequently as needed or indicated in the plan of care). Both PSW's were not aware of resident #001 having previous elopement behaviours.

Telephone interview with RN #100 by Inspector #111, indicated he/she usually checks all the doors leading to the outside at a specified time, but did not check the door leading to the outside secured on the specified date the resident had eloped and did not see the resident that shift. The RN indicated on the specified date, became aware of resident #001 missing when the two PSW's (PSW #101 & #102) reported the resident was missing. The RN indicated that approximately one month prior to the elopement, the resident had demonstrated elopement responsive behaviours and was put on increased monitoring.

Review of the health record for resident #001 indicated the resident was admitted with diagnoses that included Dementia. Review of the progress notes for resident #001 indicated approximately one month prior to elopement, the resident began demonstrating elopement responsive behaviours and continued up to two weeks before the resident had eloped.

Review of the written plan of care (in place prior to incident) for resident #001 indicated the resident was independently mobile and had impaired memory. Under the resident's pre-admission notes indicated the resident had interventions related to the potential for elopement and was placed on increased monitoring but the increased monitoring was discontinued on a specified date (as the resident had not demonstrated elopement responsive behaviour).

Interview with PSW #104 and RPN #106 indicated resident #001 usually liked to sit outside in the specified secured area during specified shifts but did not have any elopement responsive behaviours prior to the elopement.

It was identified by the Inspector that resident #001 was not kept safe and secure as the outside door leading to the secured area was left unlocked. The Inspector noted the resident had eloped through the secure outside area door that was unlocked at the time. It was noted by the Inspector that resident #001 regularly sat in the specified secured outside area during specified shifts. The Inspector also noted that on the specified date

of the elopement, there was a period of four and a half hours that resident #001 was not observed and when the resident was discovered missing. The Inspector noted all staff were not aware of resident #001 potential for exit-seeking responsive behaviours. [s. 5.]

Issued on this 2nd day of October, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2017_643111_0011
Log No. / No de registre :	016749-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 12, 2017
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
LTC Home / Foyer de SLD :	FROST MANOR 225 MARY STREET WEST, LINDSAY, ON, K9V-5K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Connie Abrams

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Order / Ordre :

The licensee shall review and revise the written policy that deals with, when doors leading to any secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, and who is responsible.

Grounds / Motifs :

1. The licensee failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Related to log # 016749-17:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for a missing resident. The CIR indicated on the same day and at a specified time, resident #001 was noted to be missing from the home.The Resident was last seen in the home approximately four hours earlier and was found approximately eight and a half hours later in hospital with injuries. The CIR indicated a search of the home revealed a door leading to a secured outside area was found unlocked. The resident was unable to recall details of the elopement due to cognitive impairment.

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to secure outside areas had a 'Nightly Door Alarm Test/Doors Locked' tick sheet which was to be completed at a specified time (four hours later than initially identified). The Administrator indicated the policy did not include checking the door leading to the secured outside area.

Review of the licensee's policy indicated only a 'Nightly Door Alarm Test/Doors Locked' tick sheet was available and indicated all exterior doors were to be checked to ensure that the door was locked, but did not indicate when this was to occur. The tick sheet did not include the identified secured outside area.

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Telephone interview with RN #100 by Inspector #111, indicated was working on the specified date resident #001 eloped, usually completes the checks of all the doors leading to the outside at a specified time, but did not check the door leading to the specified secured outside area. The RN indicated that he/she became aware resident #001 was missing when the two PSW's (PSW #101 & #102) reported the resident missing.

Interview with RPN #106 by Inspector #111 indicated the doors leading to the secured outside area is usually checked by the specified shift nurse. Interview with PSW #104 and RPN #106 indicated resident #001 usually liked to sit in the secured outside area during specified times.

A Compliance Order was warranted because although the scope only involved one resident, the severity was high, as identified by the following:
-It was identified by the inspector that a door leading to an outside secured area had a keyed lock mechanism in place which was left unlocked and not checked on either the evening or night shift shift when resident #001 eloped.

-The resident was not monitored for a period of four and a half hours until the resident was discovered missing. The resident was also not located for a period of eight and a half hours before being found in hospital with injuries to specified areas.
-It was noted by the inspector that resident #001 regularly sat in the secured area during the day and evenings and this secured outside area.
-The inspector noted it was unclear which shift/staff member was responsible for locking the door leading to the secured outside area; whether it was the evening shift or night shift RN responsible, what time (1900 or 2300) the door was to be locked, and the checklist did not direct staff to include this door when checking for alarms/locks on outside doors, and there was no policy for the checklist itself, as required in accordance with section 9. (2) of the regulation. The home was also issued a Voluntary Plan of Correction (VPC) under O. Reg. 79/10, s.9(1) during an Resident Quality Inspection during inspection # 2014_287548_0024 on September 8, 2014, which requires the home to ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. [s. 9. (2)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of September, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

Service Area Office / Bureau régional de services : Ottawa Service Area Office