Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 24, 2019	2019_786744_0031	017519-19	Critical Incident System

Licensee/Titulaire de permis

584482 Ontario Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

Long-Term Care Home/Foyer de soins de longue durée

Manitoulin Lodge
3 Main Street P.O. Box 648 GORE BAY ON P0P 1H0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

STEVEN NACCARATO (744)

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): October 17-18, 2019.

The following intake was inspected during the Critical Incident System (CIS) inspection:
-One intake related to a critical incident that the home submitted to the Director regarding a resident who was missing for more than three hours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Manager, Personal Support Workers (PSWs), Registered Nurse (RN) and residents.

The Inspector also conducted a tour of the home, reviewed residents' health records, home policies and procedures, staff schedules, and investigation notes.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, or doors that residents do not have access to, were kept closed and locked.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #001 was missing from the home for more than three hours. The CI report further identified that there were two doors in the home at the time of the incident, that were not closed or locked when it was required. The home's loading dock door leading to the outside of the home, had an alarm that was intermittently working. Also, the kitchen door that allowed access to the loading dock was not locked at all times.

The licensee's policy titled "Resident Rights, Care and Services- Safe and secure home-

Door Alarms", effective date of September 2013, stated that controls shall be provided at all doors which exit from the resident areas of the long-term care home. The policy also stated that the Administrator was to ensure that exit alarms were on at all times.

Inspector #744 interviewed the Environmental Manager who stated that they discovered after resident #001 had eloped, that the magnetic sensor on the loading dock door did not always alert an audible alarm to the nursing station staff when the door was opened.

In an interview with Inspector #744, the Administrator stated that the loading dock was not locked as staff often entered and exited that door to throw out the garbage. They further stated that all exit doors were to be closed and locked at all times. The Administrator confirmed that due to the door not being locked, resident #001 was able to use that door to elope from the home. [s. 9. (1) 1. i.]

2. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Inspector #744 interviewed the Environmental Manager who stated that the kitchen door always required a key to unlock the door and that closing the door shut would also ensure that the door was locked. They further mentioned that the kitchen door often appeared to be closed and locked; however, the door's lock did not always remain engaged in the door frame to keep the door locked.

In an interview with Inspector #744, the Administrator stated that the kitchen door must always be locked and closed, with the exception of meal service when kitchen staff were present. The Administrator confirmed that the kitchen door was not locked at the time of the incident, allowing resident #001 to enter in the loading dock area and elope from the home. [s. 9. (1) 2.]

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 all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, or doors that residents do not have access to, must be kept closed and locked. And to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

Issued on this 24th day of October, 2019

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

Original report signed by the inspector.