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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: December 29, 2023
Original Report Issue Date: October 19, 2023
Inspection Number: 2023-1301-0004 (A2)
Inspection Type: Critical Incident
Licensee: The Glebe Centre Incorporated
Long Term Care Home and City: Glebe Centre,Ottawa

Amended By	**Inspector who Amended Digital Signature**
Lisa Kluke (000725)	Lisa Kluke Digitally signed by Lisa Kluke Date: 2024.01.09 09:34:21 -05'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended as the licensee requested an extension for their Compliance Due Date (CDD) of December 30, 2023 to January 31, 2024. This extension was requested to complete the work required for Compliance Orders #001, #002 and #003 pertaining to their communication and response system.

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Long Term Care Home and City: Glebe Centre, Ottawa	
Lead Inspector Lisa Kluke (000725)	**Additional Inspector(s)** Margaret Beamish (000723)
Amended By Lisa Kluke (000725)	**Inspector who Amended Digital Signature** Lisa Kluke Digitally signed by Lisa Kluke Date: 2024.01.09 09:35:10 -05'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended as the licensee requested an extension for their Compliance Due Date (CDD) of December 30, 2023 to January 31, 2024. This extension was requested to complete the work required for Compliance Orders #001, #002 and #003 pertaining to their communication and response system.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 29 to September 1, 2023 and September 5 to 7, 2023.

The following intakes were inspected:
• Intake: #00092840 was related to alleged staff to resident abuse.
• Intake: #00093421 was related to a fall resulting in a significant change in condition of a resident.

A Training Specialist was present on site as an observer during this inspection.

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care. Specifically, a specified resident's documented care plan and profile in Point Click Care (PCC) which are parts of the plan of care, did not contain information or interventions for staff to follow when providing care while this resident was on specified infection control precautions.

Rationale and Summary:
On a specified date, it was observed that this resident was on infection control precautions. The resident's plan of care was reviewed and did not contain information or interventions for staff to follow when providing care while this resident was on these specified precautions. The resident's swabs received by the home approximately four months earlier, showed that the resident had a positive result for a specific type of infection.

In an interview with a Registered Practical Nurse (RPN), they confirmed that the resident was on precautions for this particular infection and confirmed that this should have been added to their plan of care. Additionally, this RPN stated that when a resident is on specified precautions, a stop sign logo should appear on the resident's profile in PCC providing further details to staff regarding the infection and what interventions to follow. The RPN and an Inspector reviewed this resident's profile in PCC together, and the RPN stated that there was no stop sign present in PCC when there should have been. The Manager of Infection Prevention and Control (IPAC) also confirmed in an interview that information

and interventions on providing care for any resident who is on this specified precaution should be listed in their plan of care.

Failing to ensure that the plan of care and profile in PCC set out interventions for this resident's infection control precaution potentially increased the risk of spreading infectious agents amongst other residents and staff.

Sources: Observation, a resident's plan of care and profile in PCC, a resident's infection swab results, and interviews with an RPN and Manager of IPAC. [000723]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that a student Personal Support Worker (PSW) complied with their written policy to promote zero tolerance of abuse and neglect of a resident.

Rationale and Summary:
On a specified date, the licensee submitted via the Critical Incident System an allegation from a student PSW of an alleged staff to resident abuse that was observed by the student the day prior. This allegation was not reported by the student PSW to the Student Volunteer Coordinator of the home until the following day.

The Director of Care (DOC) reported to an Inspector that the student PSW did not follow the home's policy titled Resident Care RC 4.00.00 titled Resident Abuse and Neglect Prevention Procedure, regarding immediate reporting of any alleged, suspected abuse of a resident to the nurse on duty. The DOC confirmed this student PSW was provided education on this policy and procedure during their orientation prior to starting work in the home.

As such, this student PSW failed to immediately report an alleged, suspected staff to resident abuse for a resident, which placed this resident and other residents at risk of harm.

Sources: Staff interview, a specified resident record review, interview and investigation record review with DOC and policy review for Resident Care RC 4.00.00. [000725]

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure 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.

Rationale and Summary:
On a specified date, an Inspector observed during a tour of a resident unit, that the linen chute door had a locked door handle, but the door was not closed properly and was able to be pushed open.

The following day, six doors to laundry chutes, garbage chutes, soiled utility, storage room and housekeeping storage areas were observed to not be closed properly as red fire straps were placed in the rims of these doors preventing them from closing properly.

On a specified date, a PSW indicated to the Inspector the linen chute doors are supposed to be kept closed and locked at all times. This PSW moved a red fire tag near the bottom of this door away from the door rim and indicated this was causing this door to not close properly. A housekeeper indicated to the Inspector the door to the housekeeping storage area is to be kept closed and locked and they were not aware this door needed to be pulled closed to latch the lock. A maintenance staff member indicated to the Inspector they were aware of staff moving the red fire tabs into the rim of the doorways to prevent using keys to enter these rooms and they brought it to nursing attention to prevent re-occurrence, but was an ongoing issue.

The Director of Care (DOC) indicated to the Inspector that each of these doors are to be kept closed and locked at all times.

As such, these doors to non-residential areas were not closed or locked posing a potential risk of injury to residents on these units.

Sources: Observations of resident units and interviews with staff. [000725]

WRITTEN NOTIFICATION: Elevators

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 13

The licensee has failed to ensure that the elevator in the home is equipped to restrict resident access to

areas that are not to be accessed by residents.

Rationale and Summary:
On a specified date, an Inspector observed a staff member open the rear door of the home's elevator to a non-residential area on the third floor by pushing on the door open button. The Inspector was then able to access the non-residential area from the rear door to the elevator on the fourth and fifth floors leading to the kitchen servery, a maintenance room and staff areas by pressing the door open button on the rear panel of the elevator.

The Environmental Services Supervisor (ESS) indicated to the Inspector that the elevator is equipped with a swipe pad at the front door panel for staff to access the rear non-residential areas of each floor. The ESS was not aware that the door open button on the rear panel of the elevator could open the elevator door without the need to use the swipe panel in the elevator.

As such, the elevator in the home was not equipped to restrict resident access to the rear non-residential areas of each floor posing potential risk for injury to residents in the home.

Sources: Observations, interview with ESS. [000725]

WRITTEN NOTIFICATION: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (d)

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system (RSCRS) that is available at each bed, toilet, bath and shower location used by residents.

Rationale and Summary:
On a specified date, an Inspector observed in a resident's room if any RSCRS device was in place in the bedroom and the bathroom. The RSCRS activation station was observed on the wall inside the bathroom that was not functional. A button on the activation station was observed at the resident's bedside located near the head of the resident's bed that was not functional.

A few hours later, the inspection team went to another resident's room and observed the RSCRS activation station behind the resident's bed was flashing and a light outside of the resident's room had a flashing a red light. An Inspector pulled the RSCRS activation station on the wall of the resident's bathroom which caused a red light to start flashing on the panel of the bathroom wall however there

was no audible alarm. This Inspector spoke with a Personal Support Worker (PSW) who was walking down the hallway towards the resident's room and asked if they had received a call for assistance from the RSCRS device in the resident's bathroom. This PSW indicated that they did not receive an alert as they now have a handheld device with the new RSCRS. This PSW stated that the RSCRS activation stations inside resident bathrooms are no longer in use as these were replaced with the new RSCRS devices on nursing staff and residents which was implemented last year.

On this same day, the inspection team entered the tub room on a specified resident unit and noted that it had an RSCRS activation station on the wall with a pull station cord. Another PSW informed Inspectors that this RSCRS system no longer worked as they now use the new RSCRS for the tub rooms as well. This PSW confirmed that visitors would have to push either a resident's RSCRS device or find a nursing staff member in emergencies or when assistance is required.

Four days later, the Building Systems Coordinator (BSC) indicated the home implemented a new RSCRS on July 1, 2022 and decommissioned the previous RSCRS June 30, 2023. By decommissioning the previous system, all RSCRS activation pull stations in resident rooms and bathrooms and tub/shower rooms no longer function. All residents are expected to wear the new RSCRS device on their person to be easily accessible when in bed, bathroom or tub/shower rooms. As indicated in CO #001 of this report, when direct care nursing staff or residents are not in these areas or do not have their RSCRS device as required, the remaining staff in the home and visitors would not have any method for communicating with staff for assistance or emergencies.

As such, the home is not equipped with a resident-staff communication and response system (RSCRS) that is available at each bed, toilet, bath and shower locations. This system is dependent on the resident wearing this RSCRS device posing potential risk when these devices are not applied to residents on their person as indicated in this report, and cannot call staff for assistance when required.

Sources: Observations of residents', bedrooms, bathrooms, tub/shower rooms, staff RSCRS system and devices, interviews with residents, nursing staff, BSC, and record review of the home's policy for this RSCRS system. [000725]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement the IPAC Standard issued by the Director with respect to infection prevention and control measures for a specified resident.

The home failed to ensure additional precautions, as part of the IPAC program, was followed by staff when providing care in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard).

Specifically, proper selection and disposal of Personal Protective Equipment (PPE) when providing care for this specified resident who required enhanced IPAC control measures as required in the Additional Precautions requirement 9.1 (d), under the IPAC Standard.

Rationale and Summary:
On a specified date, two personal support workers (PSWs) were observed exiting this resident's room who was on specified precautions. It was observed that both staff members were not wearing the required PPE when exiting the room. Additionally, it was observed that both PSWs did not perform hand hygiene when exiting this resident's room.

One of the PSW's stated that they had been providing personal care to the resident and should have been wearing specific PPE items when providing this type of care to this resident since they were on a specified type of precautions. A Registered Practical Nurse (RPN) confirmed that staff should have been wearing specific PPE items when providing personal care to this resident.

Not properly selecting and disposing of appropriate PPE increases the risk of transmission of infectious agents to other residents.

Sources: Observations and interviews with nursing staff. [000723]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 9.

The licensee has failed to ensure that the Infection Prevention and Control lead (IPAC lead)reviewed any daily and monthly screening results collected by the licensee to determine whether any action was required.

Rationale and Summary:
On a specified date, it was observed that a resident was on specific precaution requirements. This resident's plan of care was reviewed and did not contain information or interventions for staff to follow when providing care while this resident was on these precautions. This resident's swabs received by the

home four months earlier, showed that the resident had a positive result for a specific type of infection.

In an interview with a Registered Practical Nurse (RPN), they confirmed that the resident was on specified precautions for this infection and confirmed that this should have been added to the resident's plan of care. Additionally, this RPN and another RPN stated that the screening results of these infections are communicated to the IPAC lead who is the Manager of Infection Prevention and Control (IPAC) by either calling or emailing them. In an interview with the Manager of IPAC, they confirmed that they were not informed of this resident's positive infection result until an Inspector had informed the home that it was not in this resident's plan of care. Manager of IPAC confirmed that they are responsible for monitoring screening results which includes these types of infections and that this was not done for this resident.

The home's infection control listing in Point Click Care (PCC), showed that this resident's specific infection was not added to the tracking list until four months after the results were received by the home.

Failing to ensure that the IPAC lead reviewed screening results collected by the licensee potentially delayed determining whether further action was required for preventing the transmission of infectious agents to other residents.

Sources: Observations, record review of this resident's care plan and swab results, the home infection control listing in PCC, and interviews with nursing staff, and the Manager for IPAC. [000723]

WRITTEN NOTIFICATION: Police notification

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service was immediately notified of an alleged, suspected or witnessed incident of staff to resident abuse of a specified resident that the licensee suspected may constitute a criminal offence.

Rationale and Summary:
On a specified date, the licensee reported via the Critical Incident System (CIS) an alleged incident of staff to resident abuse, however no indication of any police service was notified.

The Director of Care (DOC) indicated to an Inspector that based on their records, no police service was ever notified of this incident of alleged staff to resident abuse.

As such, not reporting incidents of alleged, suspected or witnessed abuse of this resident to any police service, could potentially delay their investigation and pose risk to residents.

Sources: DOC interview and investigation package review and review of the licensee's policy Resident Care RC 4.00.00 Resident Abuse and Neglect Prevention. [000725]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed no later than one business day of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary:
On a specified date, a resident had a fall resulting in an injury for which they were taken to hospital resulting in a significant change in the resident's health condition. As per this resident's progress notes, the resident fell at a specified time and was transferred to hospital later this same day. A progress note on this same date in the evening stated that the resident's Substitute Decision Maker (SDM) called the home and informed them that the resident was being admitted to hospital with a specified injury requiring care.

The Critical Incident Report (CIR) submitted to the Director, indicated that this resident fell on this specified date and this was not reported to the Director until several days later.

In an interview with the Director of Care (DOC), they confirmed to an Inspector that the home was made aware on this specified date, that the resident had sustained an injury that resulted in a significant change in their health condition and that the incident was reported late to the Director.

Failing to ensure that the Director was informed no later than one business day of this incident potentially placed the resident at risk of not receiving appropriate follow-up regarding falls prevention.

Sources: Critical Incident review, a resident's progress notes and interview with DOC. [000723]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that a resident's drugs were stored in an area or a medication cart that was secure and locked.

Rationale and Summary:
On a specified date, an Inspector observed a resident's medications on top of a locked medication cart on a specified resident unit.

A Registered Practical Nurse (RPN) indicated to the Inspector that they had gone to break and forgot to return these medications inside the locked medication cart for storage.

As such, the licensee did not comply with ensuring these medications were not stored in a medication cart that was secure and locked posing risk to residents accessing medications.

Sources: Observations of medication cart on a specified resident unit and an interview with an RPN. [000725]

WRITTEN NOTIFICATION: Administrator

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 249 (3) (d)

The licensee has failed to ensure that everyone hired as an Administrator, has successfully completed or, subject to subsection (5), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time.

Rationale and Summary:
On a specified date, the Chair of the Board of Directors indicated to an Inspector that they were the current interim Executive Director (ED) in the home until their new ED begins. The interim ED indicated they had not completed or were enrolled in any Administrator or management program that was a minimum of 100 hours in duration of instruction time.

Failure to have a qualified Executive Director posed potential risk to the daily operations and management of the home that could affect residents and staff.

Sources: Interview with the interim ED. [000725]

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.

The licensee has failed to request and receive approval of the Director prior to commencing an alteration for the resident-staff communication and response system (RSCRS) used in the home.

Rationale and Summary:
On a specified date, an Inspector heard a resident calling out for staff assistance from their bedroom. The Inspector was not able to locate any RSCRS in this bedroom. A PSW reported the home no longer used the RSCRS activation pull stations mounted on walls as they have a new RSCRS system for staff and residents wear and use.

The Building Systems Coordinator (BSC) indicated to an Inspector that they implemented a new RSCRS on July 1, 2022. The BSC was not aware that the renovation request to their RSCRS was required to be made to the Director prior to implementation, but the Executive Director (ED) at the time may have made this request as the ED provided the BSC the approval for the installation of the new system.

The Director of Operations indicated they had replaced the previous ED for approximately seven months and they were not aware of any request to the Director for their new RSCRS.

The Chair of the Board of Directors, acting as the current interim ED in the home reported they were not aware of any request made to the Director regarding the alteration and installation of the new RSCRS prior to installation in 2022.

On a specified date, the Capital Developments branch of the Ministry of Long-Term Care (MLTC) indicated in an email to an Inspector that they had not received any submission requests to the Director to alter the RSCRS at the Glebe Centre to date.

Failure to receive approval prior to the alteration to an existing approved RSCRS prevented this new system from being reviewed to meet the legislative requirements posed potential increased risk to residents.

Sources: Observations of several residential areas in the home, interviews with a resident, nursing staff, the BSC, the Director of Operations, the interim ED and the Capital Development branch of MLT. [000725]

COMPLIANCE ORDER CO #001 Communication and response system

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Ensure the resident-staff communication and response system (RSCRS) can be easily seen, accessed, and used by residents, staff, and visitors at all times;
2. Ensure that availability of the RSCRS for all staff, visitors and residents does not depend on a person being present who is wearing an RSCRS device;
3. Ensure all residents, staff, and visitors have been informed of this RSCRS made available in all areas accessible by residents and document how this was provided;
4. Document three weekly audits alternating resident areas to ensure the RSCRS is easily seen, accessible and functional to activate a call for assistance by residents, staff, and visitors. These audits will include name and signature, date, time, location, and staff names responding to these calls at point of activation as per CO #001; These audits will be performed until such time the Ministry of Long-Term Care has deemed that the licensee has complied with this order; and
5. Document corrective actions and outcomes related to these audits.

Grounds

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system (RSCRS), that can be easily seen, accessed, and used by residents, staff and visitors at all times.

The design of the licensee's new RSCRS is such that calls for assistance from residents, staff and visitors are to be made by pressing an activation button on a device typically worn on a wrist or on a lanyard (RSCRS device). These devices are currently only provided to residents and direct care nursing staff members, with the expectation they are worn at all times.

Rationale and Summary:

On a specified date, an Inspector heard a resident call out from their bedroom for assistance. The Inspector could not locate an RSCRS device at the resident's bedside, which is a requirement identified

in this report in NC #005, nor could the inspector easily locate an RSCRS device on the resident. The resident's RSCRS device was later located attached to the back of their mobility device where the resident could not access it.

On this same specified date, another Inspector observed a second resident without any RSCRS device on their person or their mobility device.

An Inspector conducted a return observation six days later for the second resident who was this time without any RSCRS device on their person or their mobility device. The Inspector brought this to the attention of the Building Systems Coordinator (BSC) and the Director of Environmental Services (DES) who then completed a tracking of this device and located this second resident's RSCRS device inside a storage room attached to a spare mobility device. DES indicated they were not aware of how long this resident's device was in the storage room prior to locating it.

On a specified date, a PSW indicated some residents do not like to wear the bracelet as it bothers them. This PSW indicated this second resident cannot wear the bracelet as it had potential to cause an alteration in skin integrity, so alternatives were to pin the device to resident's clothing or apply it to a lanyard.

On a specified date, a third resident had their RSCRS device clipped to the back of the mobility device while seated in their bedroom next to their bed. The RSCRS device could not be accessed by this resident. A PSW indicated the resident can use the RSCRS device as they are often using it to make calls for assistance at the beginning of the day shift. This PSW indicated they were not sure why the RSCRS device was located on the back of the resident’s mobility device.

On a specified date, a visitor was with a resident in a lounge on a resident unit. The visitor asked the inspection team if they were staff members, as the visitor needed help to reposition this resident. An Inspector asked them to use the resident's RSCRS device, but this visitor was not aware of it or how to use it to call for assistance. This visitor indicated they visit regularly to the home, but they were not made aware of this new RSCRS device or how to use it.

An activity staff member indicated to an Inspector that they do not have access to an RSCRS device unless it is on the resident during activities. This Activity staff member indicated their department was not a part of the training for the new RSCRS nor were they informed how to use them. This Activity staff member indicated there are times during the day when direct care nursing staff are inside resident rooms and tub rooms and therefore no nursing staff are available, and they can only call out verbally for assistance. This Activity staff member indicated there is no way to signal an emergency with this RSCRS device.

On a specified date, an Inspector observed two specified residents walking in a resident unit and both were not wearing any RSCRS devices. Both residents were independently ambulatory and a PSW confirmed after verifying both residents, that they did not have any RSCRS device on their person.

On this same date, another Inspector observed two other residents also on this resident unit without any RSCRS device on their person or their mobility devices. Another PSW informed this Inspector that the residents do not have their RSCRS devices on them as they are constantly removing them. This PSW further stated that most residents on this resident unit do not wear their RSCRS devices as they remove them and they end up in laundry.

On this same date, three PSW's indicated to an Inspector that they did not have their RSCRS devices while working on this resident unit. One PSW indicated they did not know where their device was located, another PSW indicated their device was broken and another PSW indicated they had left their device at home in the pocket of another uniform.

The PSW Supervisor indicated to an Inspector that PSW staff should ensure the RSCRS devices are applied to the resident's person and are not supposed to be attached to their mobility devices. PSW Supervisor further indicated that residents and nursing staff are to always be wearing these RSCRS devices during their shifts so they can be easily seen and used when assistance is required.

An RPN indicated to an Inspector the RSCRS devices are supposed to be applied to the resident's wrist, clipped to their clothing, or worn on a lanyard.

The BSC and DES indicated to an Inspector that only residents and direct nursing staff in the home were trained and required to wear these RSCRS devices. Other department staff in the home were not trained and have not been provided with these RSCRS devices at this time.

Therefore, the present RSCRS can only be seen, accessed, and used by all residents, staff, and visitors if a resident or direct care nursing staff member is present in that location and is wearing an RSCRS device. If neither are present and wearing the RSCRS device, then the RSCRS is not accessible for residents, staff, and visitors to call for assistance.

As such, the home is not equipped with an RSCRS that can be easily seen, accessed, and used by residents, staff, and visitors. This poses a significant risk to resident health and safety as the ability for all users to make a call for assistance when needed, cannot be assured.

Sources: Observations of staff using these RSCRS devices, resident observations, interviews with several staff members, visitors, the PSW Supervisor, DES, and BSC. [000725]

This order must be complied with by January 31, 2024

COMPLIANCE ORDER CO #002 Communication and response system

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (c)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Ensure that the home is equipped with a resident-staff communication and response system (RSCRS) that allows calls to be cancelled only at the point of activation. The point of activation would be any person with a wearable RSCRS device and any area as per CO #003;
2. Immediately develop a procedure where staff must go to the point of activation before cancelling the call for assistance, until a system is available to cancel calls only at the point of activation;
3. Ensure this procedure is implemented;
4. Provide education to all staff on this procedure, and that this education is documented;
5. Document twice weekly audits alternating resident units and shifts to ensure this new procedure is being followed throughout the home. These audits will include signature, date, time, resident and staff names and units for each audit to support that a member of the management team or delegate has conducted these audits. The audits will be performed until such time the Ministry of Long-Term Care has deemed that the licensee has complied with this order; and
6. Include documented corrective actions required and outcomes.

Grounds

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system (RSCRS) that allows calls to be cancelled only at the point of activation.

Rationale and Summary:

On a specified date, an Inspector observed the functioning of the home's new RSCRS used between the residents and a Personal Support Worker's (PSW) handheld RSCRS device on a specific resident unit. A resident in a specified room RSCRS device was activated and the Inspector observed that this PSW could

accept this call from their handheld RSCRS system device and could then cancel this call down the unit hallway, at a significant distance from the point of activation, which was the resident in this specified room.

The Building Systems Coordinator (BSC) indicated the RSCRS calls are equipped to be cancelled within five feet of the point of activation or they can be cancelled from anywhere in the home at this time and not at the point of activation.

Failure to ensure that the home's RSCRS allows for calls to be cancelled at the point of activation only, creates the risk that calls could be cancelled by direct care nursing staff without first determining why a resident, other staff, or a visitor had called for assistance. This creates the possibility that care and assistance would not be provided when it is necessary and poses a significant risk to resident health and safety.

Sources: Multiple observations of the new RSCRS devices, interviews with nursing staff and the BSC. [000725]

This order must be complied with by January 31, 2024

COMPLIANCE ORDER CO #003 Communication and response system

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (e)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Ensure that the home is equipped with a resident-staff communication and response system (RSCRS) that is available in every area accessible by residents; which shall include each bed, toilet, bath and shower locations used by residents;
2. Ensure that a resident or direct care nursing staff member is not required to be present in these locations for an RSCRS to be available;
3. Document three weekly audits alternating resident areas to ensure the RSCRS is in place and functional to activate a call for assistance. These audits will include name and signature, date,

time, location, and staff names responding to these calls at the point of activation as per CO #002. These audits will be performed until such time the Ministry of Long-Term Care has deemed that the licensee has complied with this order; and

4. Document corrective actions and outcomes related to these audits.

Grounds

The Licensee has failed to ensure that the home is equipped with a resident-staff communication and response system (RSCRS) that is available in every area accessible by residents.

Rationale and Summary:

On a specified date, the Inspections team entered the activity room on a specified resident unit and noted that there was an RSCRS activation station on the wall and it was not functional.

An Inspector later observed on this date that the courtyard off a secured unit had no RSCRS available in this resident accessible area.

Another Inspector noted on a specified resident unit, that the TV room/lounge/activity rooms did not have any RSCRS available. This Inspector also observed the large garden area off a resident unit had an RSCRS activation station on the wall outside in the garden area that was not functional.

The Building Systems Coordinator (BSC) confirmed with the Inspector that the previous RSCRS that had pull stations fixed into place in resident accessible areas was decommissioned June 30, 2023, which included public washrooms, resident lounge and program/activity spaces, resident dining areas, beauty parlour/barber shop and outdoor garden spaces. Their present RSCRS requires calls for assistance to be made from a wearable device. The BSC confirmed only residents and direct care nursing staff members are issued the wearable RSCRS devices. The BSC indicated no other staff or visitors have access or training for the new RSCRS devices at this time.

The home does not have RSCRS devices, from which a call for assistance can be made, fixed into place in resident accessible areas. The present RSCRS is therefore only available for all residents, staff, and visitors (as indicated in this report in NC #005) in a resident accessible area if there is a resident or direct care nursing staff member present and wearing an RSCRS device. If neither of them are present, then the RSCRS is not available in a resident accessible area. As noted in CO #001, inspectors found widespread examples during the inspection of residents and some direct care nursing staff members not wearing an RSCRS device.

As such, the home is not equipped with an RSCRS that is available in every area accessible by residents. This presents a significant risk to residents' health, safety, and quality of life as not all residents, staff and visitors are able to access and use the RSCRS to make calls for assistance.

Sources: Observations of resident areas in the home, interviews with direct care nursing staff, activity staff, dietary staff, the BSC and record review of the 1999 version design manual. [000725]

This order must be complied with by January 31, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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