Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 3, 2023	
Original Report Issue Date: March 30, 2023	
Inspection Number: 2023-1401-0002 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: Lanark Heights Long Term Care Centre, Kitchener	
Amended By Jessica Bertrand (722374)	**Inspector who Amended Digital Signature** Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2023.04.05 09:48:12 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

The licensee inspection report has been revised to reflect the change of rescinding non-compliance (NC) #002, O. Reg. 246/22, s. 102 (2) (b), a written notification of infection prevention and control program. The inspection #2023-1401-0002 was completed on March 27, 2023.

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Lead Inspector Jessica Bertrand (722374)	**Additional Inspector(s)** Alicia Campbell (741126)
Amended By Jessica Bertrand (722374)	**Inspector who Amended Digital Signature** Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2023.04.05 09:47:47 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

The licensee inspection report has been revised to reflect the change of rescinding non-compliance (NC) #002, O. Reg. 246/22, s. 102 (2) (b), a written notification of infection prevention and control program. The inspection #2023-1401-0002 was completed on March 27, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-16, 22-24, 27, 2023.

The following intake(s) were inspected:

- Intake: #00007672 related to fall prevention and management;
- Intake: #00017599 and #00022374 [Complaint] related to improper care and neglect, continence care, and training;
- Intake: #00020272 [Complaint] related to fall prevention and management and nutritional care.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Communication and Response System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated, where the call was coming from.

Rationale and Summary
The home's Call Bells Policy documented when the call bell system malfunctioned, a process for monitoring of residents would be implemented and documented to ensure safety and care needs of resident are being met until such time the system is functioning again. This may include, but is not limited to, scheduled monitoring of residents, providing alternative methods of notification, deploying team members from other departments to assist with monitoring, using call bell system from empty rooms, and safety checks.

At the time of inspection, inspector #722374 observed the call bell light flashing for a resident room. After approximately 14 minutes, the resident was overheard crying from their room, trying to leave the washroom. When approached, the resident indicated they had been waiting for assistance off the toilet and they were in discomfort.

A staff member indicated they helped the resident onto the toilet approximately 30 minutes prior to the inspector hearing the resident crying and lost track of time while helping other residents. They did not have a mobile phone attached to the call bell system as the phone had been missing for the last month. They had to rely on their partner who had a phone, the lights flashing above the resident room and the alarm sounding at the nursing station. A staff member indicated the nursing station call bell alarm was

not audible from the other side of the resident home area.

A registered staff member stated that when a phone went missing, another registered staff member was notified so they could call the individual that took the phone so it would be returned. While they waited, staff did not have anything in its place.

A mobile phone audit was conducted at the home at the time of inspection which indicated there were four assigned phones for each home area in addition to one mobile phone for the registered staff member on the unit. The audit indicated four phones were missing across three RHAs.

An Environmental Services (ES) staff member indicated phones that were documented as lost were not replaced or provided alternatives.

The ES Manager indicated when a mobile phone went missing, staff could request a back up pager from maintenance. Pagers had not been used for a specified number of years, until they were issued for malfunctioning phones at the time of the audit. They confirmed staff should have requested a pager when a phone went missing.

By failing to ensure all staff was equipped with a resident-staff communication and response system that clearly indicated where the call was coming from, a resident was left in discomfort while waiting for assistance.

Sources: Point Click Care notice, Mobile Phone Audit, interviews with staff members, and the ES Manager.

[722374]

(A1)
The following non-compliance(s) has been amended: NC #002

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22s. 102 (2) (b)