Ontario

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

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'Inspecteur (No) :	KELLY-JEAN SCHIENBEIN (158)
Inspection No. / No de l'inspection :	2012_140158_0015
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Sep 13, 14, Oct 11, 12, 29, 30, Nov 1, 2012
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TONY PARMAR

To THE CITY OF GREATER SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

Ministére 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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2012_140158_0002, CO #002

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for all residents who display responsive behaviours that sets out clear directions to staff and others who provide direct care to the residents.

Grounds / Motifs :

1. Resident # 05 was found on the floor in August 2012. Subsequent to this incident, the resident fell again two days later at and sustained a head injury. The resident was transferred to hospital where they later died. The Inspector reviewed the plan of care for resident # 05 on September 14/12. Under sleep, it was documented that the resident prefers to get up at 07:30hr. Under dressing, it was documented that the resident required constant supervision and extensive assistance of 1 staff. Staff # S-107 stated that the resident often woke early (06:00hr) and would attempt to do their am care as well as to dress themselves, refusing assistance at times. Staff # S-107 added that staff would return and then assist to "fix the resident up". Strategies for refusing care were found but are generic to "care". The resident's plan of care does not reflect the resident's early morning routine and does not provide clear direction with regards to managing the resident's refusal to dress. The licensee did not ensure that there is a written plan of care that sets outs clear direction to staff and others who provide direct care to resident # 05. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (c)] (158)
2. A previous compliance order was issued under s. 6 (1): 2012_140158_0002, CO #002. (158)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2012

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2012_099188_0016, CO #901

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall fully implement the previously submitted plan, which outlines immediate short-term measures and longterm strategies that will ensure the resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times and clearly indicates when activated where the signal is coming from.

Grounds / Motifs :

1. On September 13/12 at 12:25h, the Inspector observed that the white light outside of a resident's room in one area of the home was illuminated. The resident stated that they did not press the button and did not need assistance. The Inspector noted that the alert message identifying that a resident needed assistance was not on the computer screen. Staff # S-100 who was at the desk was not aware that the light identifying resident assistance was illuminated. The Inspector confirmed with staff # S-108 that they did not receive a page. Staff # S -100 confirmed that when the resident calls, a message on the computer screen is displayed, the light outside the resident's room illuminates white and that the staff's pager rings alerting a call for assistance from a resident. Together with staff # S-100, the Inspector checked the Versus System three times on September 13/12. During the first test, the white indicator light outside a resident's room illuminated however, staff # 108 did not receive the page nor was a message displayed on the computer. During the 2nd test, the green indicator light outside a resident's room remained on even though staff # S-100 exited the room and that the white light outside a resident's room located across the hall from where the test was being conducted illuminated even though there was no resident present in the room. The white lights outside the rooms did not illuminate nor did the staff pager ring when resident's # 03 and resident # 05 badges were pressed during the third test. The licensee failed to ensure the home is equipped with a resident-staff communication and response system which clearly indicates when activated where the signal is coming from. [O.Reg. 79/10, s.17 (1) (f)] (158)
2. In August 2012, staff # S-103 documented in resident # 05 progress notes that the resident was found on the floor on their buttocks, two bedrooms down from their room. Staff S-103 documented that the resident did not have their Versus badge on when Staff-103 assessed the resident's vital signs post fall. The Program Co-ordinator identified that the "Versus Detail by Badge" system tracks the resident's badge location, the time into the location and the time out. A print out of the "Versus Detail by Badge" status identified that the resident's badge was in their room at time of the resident's fall. It was also documented by staff on the "Versus Daily Check" list that resident # 05 Versus badge was missing at the time of the fall. The licensee did not ensure that the resident-staff communication and response system was easily accessed and used by residents. [O.Reg. 79/10, s.17 (1) (a)] (158)
3. A previous compliance order was issued under s. 17 (1) : 2012_140158_0005, CO # 901. (158)
4. As per the home's Versus call bell system policy, the following was documented: " when a resident uses his/her badge, the alert system will illuminate the white light outside the room to alert staff to the location of the call "; " when the resident care staff goes into the room/area where a resident or other person made the call, the call is automatically cancelled by the system. The white dome light outside the room will go out and a green light will illuminate to show the presence of a staff member in the room" and " the green light automatically shuts off when the staff member exits the room". It was noted during the walk about on September 12/12 at 00:05h that the green light illuminated outside a resident's room. The Inspector checked the room and there was no resident in the room or bathroom. It was also noted that the Versus Personal Alert System (resident call tracker) which is displayed on the computer was not on the screen. Staff # S-101 confirmed that the resident was not in the building and staff was unable to cancel the light. The Inspector observed that several green lights in this resident home area were illuminated at 03:00hr however the staff were not in the residents' rooms at this time. Staff # S-101 identified that the lights could not be cancelled. One of the Program Managers identified on September 13/12 that there are 2 "ghost rooms" in two resident home areas, where the lights illuminate without activation. The Inspector spoke with staff # S-105 and staff # S-106 who were working in one of these areas on September 13/12 and identified that on September 13/12, the call light in the dining room could not be cancelled and that the white light in resident # 6 room did not illuminate when pressed. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system which clearly indicates when activated where the signal is coming from. [O.Reg. 79/10, s.17 (1)(f)] (158)

This order must be compiled with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2012

Ontario

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

Ministére 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

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2012_140158_0002, CO #003

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall ensure that for each resident demonstrating responsive behaviours that strategies are developed and implemented to respond to these behaviours.

Grounds / Motifs :

1. The health care record for resident # 02 was reviewed by the Inspector on September 12/12. Resident # 02, who resides in the home, has dementia and their safety is at risk should the resident leave the building. In August 2012, it was documented in resident # 02 progress notes that the resident was at the main desk wanting the bus schedule so they could leave the building. In September 2012, resident # 02 was found near the main entrance trying to leave, stating they wanted to go home. Resident # 2 responsive behaviour of wandering the halls was documented in the assessment completed in August 2012, however resident # 2 behaviour of exit seeking was not. Resident # 02 plan of care identified that the resident wanders into other rooms and interventions such as "redirect and assist the resident with locating their room" was documented. Although, the plan of care identified strategies to implement when resident # 02 wanders in other rooms, there were no strategies developed or clearly identified strategies to implement when the resident exit seeks. The licensee did not ensure that, for each resident demonstrating responsive behaviours, that strategies are developed and implemented to respond to these behaviours. [O. Reg. 79/10, s. 53 (4)] (158)
2. A previous compliance order was issued under s. 53(4): 2012_140158_0002, CO #003. (158)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2012

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

issued on this 1st day of November, 2012

Signature of inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'Inspection	inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Sep 13, 14, Oct 11, 12, 29, 30, Nov 1, 2012	2012_140158_0015	Follow up

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

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

KELLY-JEAN SCHIENBEIN (158)

inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Program Coordinators, Manager of Therapeutic Services, Registered Nursing Staff, Personal Support Workers, residents, and families.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, observed meal service, reviewed residents' health care records, and reviewed various policies and procedures.

The following logs were reviewed as part of this Follow Up inspection: S-000551-12 and S-000681-12

The following inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. A previous compliance order was issued under s. 6 (1): 2012_140158_0002, CO #002.
2. The Inspector arrived on one resident home area at 23:50h on September 12/12 and observed that resident # 01, who did not have their glasses on, was sitting in the wheel chair (w/c) in the dining room leaning forward, pacing with the w/c and moving dining room chairs. Staff # S-107 called out to the resident but resident # 01 who has severe hearing impairment was observed by the Inspector to focus on moving a dining room chair. The resident was observed to become startled and became more agitated (pacing and moving chairs) after staff # S-107 approached the resident from behind at 00:15h. The plan of care identified that the resident is to be approached from the front and to gain their attention prior to speaking or touching them. The plan of care also identifies that the resident is to always wear their glasses at all times. The licensee did not ensure that the care set out in the plan of care was provided to resident # 01. [LTCHA 2007, S.O. 2007, c. 8, s. 6. (7)]
3. On September 13/12, the Inspector reviewed the plan of care for resident # 02 who was assessed in August 2012 as a risk to fall related to poor judgement and unsteady gait. The plan of care identified that a chair sensor is to be applied when the resident is in their wheelchair (w/c).
It was documented two times in June 2012, three times in July 2012, three times in August 2012, and three times in September 2012 that the resident was self transferring from bed to w/c, from the w/c to toilet and was found on the floor three times with minimal injury (redness and bruising). In July 2012, the use of a chair sensor was initiated. It was documented that the cord to the sensor was lost in August 2012. A referral to OT requesting a cord replacement for the chair sensor was not completed.
On September 13/12, the Inspector observed that a chair sensor was not on the resident's w/c when the resident was by the water dispenser on one unit. Staff # S-102 stated that resident # 02 did not have a chair sensor applied on their w/c as the cord was missing and that the resident "really doesn't need it".
The Manager of Therapeutic Services confirmed on September 13/12 that the use of the chair sensor for resident # 02 was still being trialed and that there was no referral sent requesting a replacement of the censor cord. The licensee did not ensure that the care set out in resident's plan of care was provided to resident # 02. [LTCHA 2007, S.O. 2007, c.8, s. 6 (7)]
4. Resident # 05 was found on the floor in August 2012. Subsequent to this incident, the resident fell again two days later and sustained a head injury. The resident was transferred to hospital where they later died. The Inspector reviewed the plan of care for resident # 05 on September 14/12. Under sleep, it was documented that the resident prefers to get up at 07:30hr. Under dressing, it was documented that the resident required constant supervision and extensive assistance of 1 staff. Staff # S-107 stated that the resident often woke early (06:00hr) and would attempt to do their am care as well as to dress themselves refusing assistance at times. Staff # S-107 added that staff would return and then assist to "fix the resident up". Strategies for refusing care were found but are generic to "care". The resident's plan of care does not reflect the resident's early morning routine and does not provide clear direction with regards to managing the resident's refusal to dress. The licensee did not ensure that there is a written plan of care that sets outs clear direction to staff and others who provide direct care to resident # 05. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (c)]

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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. A previous compliance order was issued under s. 17 (1) : 2012_140158_0005, CO # 901.
2. As per the home's Versus call bell system policy, the following was documented: " when a resident uses his/her badge, the alert system will illuminate the white light outside the room to alert staff to the location of the call "; " when the resident care staff goes into the room/area where a resident or other person made the call, the call is automatically cancelled by the system. The white dome light outside the room will go out and a green light will illuminate to show the presence of a staff member in the room" and " the green light automatically shuts off when the staff member exits the room". It was noted during the walk about on September 12/12 at 00:05h that the green light illuminated outside a resident's room. The Inspector checked the room and there was no resident in the room or bathroom. It was also noted that the Versus Personal Alert System (resident call tracker) which is displayed on the computer was not on the screen. Staff # S-101 confirmed that the resident was not in the building and staff was unable to cancel the light. The Inspector observed that several green lights in this home area were illuminated at 03:00hr however the staff were not in the residents' rooms at this time. Staff # S-101 identified that the lights could not be cancelled. One of the Program Managers identified on September 13/12 that there are 2 "ghost rooms" located in two resident home areas where the lights illuminate without activation. The Inspector spoke with staff # S-105 and staff # S-106 who were working in one of these areas on September 13/12 and identified that on September 13/12, the call light in the dining room could not be cancelled and that the white light in resident # 6 room did not illuminate when pressed. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system which clearly indicates when activated where the signal is coming from. [O.Reg. 79/10, s.17(1)(f)]
3. In August 2012, staff # S-103 documented in resident # 05 progress notes that the resident was found on the floor on their buttocks, two bedrooms down from their room. Staff S-103 documented that the resident did not have their Versus badge on when Staff-103 assessed the resident's vital signs post fall. The Program Co-ordinator identified that the "Versus Detail by Badge" system tracks the resident's badge location, the resident's time into the location and the time out. A print out of the "Versus Detail by Badge" status identified that the resident's badge was in the resident's room at the time of the resident's fall. It was also documented by staff on the "Versus Daily Check" list that resident # 05 Versus badge was missing at the time time of the resident's fall. The licensee did not ensure that the resident-staff communication and response system was easily accessed and used by residents. [O.Reg. 79/10, s.17 (1)(a)]
4. On September 13/12 at 12:25h, the Inspector observed that the white light outside of a resident's room was illuminated. The resident stated that they did not press the button and did not need assistance. The Inspector noted that the alert message identifying that a resident needed assistance was not on the computer screen. Staff # S-100, who was at the desk, was not aware that the light identifying resident assistance was illuminated. The Inspector confirmed with staff # S-108 that they did not receive a page. Staff # S-100 confirmed that when the resident calls, a message on the computer screen is displayed, the light outside the resident's room illuminates white and that the staff's pager rings alerting a call for assistance from a resident. Together with staff # S-100, the Inspector checked the Versus System three times on September 13/12. During the first test, the white indicator light outside a resident's room illuminated however, staff # 108 did not receive the page nor was a message displayed on the computer. During the 2nd test, the green indicator light outside a resident's room remained on even though staff # S-100 exited the room and that the white light outside a resident's room located across the hall from where the test was being conducted, illuminated even though there was no resident present in the room. The white lights outside the rooms did not illuminate nor did the staff pager ring when resident's # 03 and resident # 05 badges were pressed during the third test. The licensee failed to ensure the home is equipped with a resident-staff communication and response system which clearly indicates when activated where the signal is coming from. [O.Reg. 79/10, s.17(1)(f)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. A previous compliance order was issued under s. 53(4): 2012_140158_0002, CO #003.
2. The health care record for resident # 02 was reviewed by the inspector on September 12/12. Resident # 02, who resides in the home, has dementia and their safety is at risk should they leave the building. In August 2012, it was documented in resident # 02 progress notes that the resident was at the main desk wanting the bus schedule so they could leave the building. In September 2012, resident # 02 was found near the main entrance trying to leave, stating they wanted to go home. Resident # 02 responsive behaviour of wandering the halls was documented in the assessment completed in August 2012 however resident # 02 behaviour of exit seeking was not. Resident # 02 plan of care identified that the resident wanders into other rooms and interventions such as "redirect and assist the resident with locating their room" was documented. Although, the plan of care identified strategies to implement when resident # 02 wanders in other rooms, there were no strategies developed or clearly identified strategies to implement when the resident exit seeks. The licensee did not ensure that, for each resident demonstrating responsive behaviours, that strategies are developed and implemented to respond to these behaviours. [O. Reg. 79/10, s. 53 (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #003	2011_099188_0035	158
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001	2012_140158_0002	158
O.Reg 79/10 r. 30.	CO #001	2011_099188_0035	158
O.Reg 79/10 r. 131.	CO #002	2011_099188_0035	158

Issued on this 1st day of November, 2012

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