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**

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JESSICA LAPENSEE (133) |
| **Inspection No. / No de l'inspection :** | 2013_304133_0033 |
| **Log No. / Registre no:** | S-00388-13 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Dec 13, 2013 |
| **Licensee / Titulaire de permis :** | CORPORATION OF THE TOWN OF KIRKLAND LAKE<br>3 KIRKLAND STREET WEST, POSTAL BAG 1757,<br>KIRKLAND LAKE, ON, P2N-3P4 |
| **LTC Home / Foyer de SLD :** | TECK PIONEER RESIDENCE<br>145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Nancy Theriault |

To CORPORATION OF THE TOWN OF KIRKLAND LAKE, 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**

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Ontario

**Ministry of Health and Long-Term Care**

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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

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**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. 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 take measures to ensure that the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation. The licensee shall ensure that, at all times, nursing staff must go to the resident's location, from which they have made a call, in order to cancel the call. For example, nursing staff must have to enter a bedroom in order to cancel a call being made from the bedroom, and nursing staff must have to enter a washroom in order to cancel a call being made from a washroom.

The licensee will include, but not be limited to, the following measures in their efforts to achieve compliance with O. Reg. 79/10, s. 17 (1) (c):

a) The licensee must move the bedroom ceiling system sensors deeper into the bedrooms, so that the sensors do not detect the staff Personal Alert Badge (PAB) from the hallway. If this does not prevent the bedroom ceiling sensors from detecting the staff PABs, and thereby cancelling a call, from the hallway, the licensee must find alternate means of achieving this.

b) The licensee must install system sensors within the washroom of all private and ward rooms, so that a call made from within a washroom cannot be cancelled in the bedroom, without going into the washroom. This includes all private washrooms within the Toburn unit. Alternately, the licensee may find alternate means to achieve this, which must be compliant with O. Reg. 79/10, s.17.(1) in its entirety.

c) The licensee must install system sensors in any/all other locations where they may be lacking, such as in the back corner of the Park Lane Dining Room/Park Lane Lounge area, so that calls originating from such a location can be cancelled only from that location.

d) The licensee will develop and implement a comprehensive resident PAB testing program, which will verify that the system allows calls originating from areas throughout the home only to be cancelled from those areas and ensure the success of the above noted measures. This is to be done in tandem with the resident PAB testing program, as required per Compliance Order #002 , which will verify that the system clearly indicates where signals from such locations are coming from.

e) The licensee will ensure, for example, the possible impact of the position of a door, such as a washroom door, is considered when doing the testing as prescribed above (i.e - if a door is slightly ajar and this allows nursing staff with a PAB to cancel a call from that washroom, without going into that washroom).

**Grounds / Motifs :**

1. The home is equipped with a wireless resident-staff communication and response system (the system). All residents and all nursing staff are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. The system ceiling sensors, throughout the home, interface with these PABs, indicating the location of the person wearing the PAB when the system last sensed them. Every nursing staff member is required to wear their PAB at all times while on shift. The vast majority of residents wear their PABs at all times as their primary method to call for assistance, from anywhere within the building. As well, in every common area, and in all resident washrooms, there is a remote pull station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to incoming calls for

assistance. Above all resident bedrooms and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station in that area. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, when the closest ceiling sensor detects their PAB, and this cancels the call for assistance and signals that a staff person is present and responding to the call.

2. The licensee has failed to comply with O. Reg. 79/10, s. 17.(1)(c) in that the home is not equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation. During the follow up inspection, the following evidence was found that illustrates ongoing concerns with regards to the system. This presents a widespread pattern of risk to the residents of the home.

3. In the company of the Environmental Services Manager (ESM), on November 26th and 27th, 2013, the inspector noted that in private bedrooms with a private bathroom, and in rooms with two beds and a bathroom, referred to as ward rooms by the home, there are no system ceiling sensors in the bathrooms. If a call is made from a resident PAB or from a remote call station on the wall next to the toilet in these bathrooms, the call can be cancelled without going into the bathroom. Once the bedroom ceiling sensor detects the staff PAB, the call is cancelled. Staff do not have to go to the point of activation, which is in the bathroom, in order to cancel a call originating from that location in these 2 types of bedrooms. The lead hand for housekeeping services informed the inspector that there are 39 such bedrooms in the home, affecting 53 of 81 residents. The system does not allow calls to be cancelled only at the point of activation.

4. In addition to the above, in the company of the ESM, on November 27th, 2013, the inspector noted that calls made from a resident PAB, from within a bedroom, can be cancelled from outside of a bedroom. This was first observed in bedrooms in the Lakeshore care unit, #L7, #L3, #L4, #L9, #L2. Wearing a staff PAB, the inspector was able to activate the green dome light above the bedroom doorways, and thereby cancel the call, while standing in the hallway. The bedroom ceiling sensors were able to detect the staff PAB from the hallway, given the location of the sensors. The distance varied, from several inches from the entrance, up to approximately 2 ft. from the entrance to the bedroom. Considering both issues together, in bedrooms #L3 and #L2, for example, the inspector was able to cancel a call originating from the private bathroom without entering the bedroom. Following this discovery, the maintenance assistant

began moving ceiling sensors, which are within ceiling tiles, deeper into the bedrooms, which appeared to resolve the issue of calls being cancelled from the hallway. This was observed by the inspector in #L2, #L4 and #L9. This does not resolve the issue of calls from private washrooms being cancelled from within the bedroom, without having to enter the bathroom. The system does not allow calls to be cancelled only at the point of activation.

5. In the company of the ESM, on November 26th, 2013, the inspector asked resident #001 to make a call with the PAB they were wearing. The resident was sitting at a table within the Park Lane dining room, in the back corner area, and their PAB was clipped to their shirt, beneath a zip up fleece sweater. Resident #001 unzipped their outer top, took the PAB out and pressed the button to make a call. A call was made, however a PSW in the area, staff member #S100, showed the inspector that their pager indicated the call was coming from resident #001's bedroom, #M9, which is near the end of the Macassa care unit hallway. The inspector, the ESM and staff #S100 noted that the white dome light was illuminated above the resident's bedroom doorway, indicating a call was being made from that bedroom. In order to cancel the call made by resident #001 in the dining room, the ESM had to take a staff PAB down the Macassa unit hallway, to the resident's bedroom. The ESM entered the bedroom, the ceiling sensors detected the staff PAB, the green dome light illuminated and the white dome light turned off. The resident's bedroom, where the call was cancelled, was not the point of activation. The system does not allow calls to be cancelled only at the point of activation.

6. After working with resident #001, the ESM and the inspector asked resident #002 to make a call with the PAB they were wearing. Resident #002 was seated at the table next to where resident #001 had been seated, in the area that is formally referred to as the Park Lane Lounge. The Park Lane Dining Room and Park Lane Lounge are one continuous L shaped space. The resident had their PAB attached to their shirt, with a button up sweater overtop, which was not obscuring the PAB. Resident #002 pressed the button and made a call. Staff member #S100 showed the inspector that their pager indicated that resident #002 required assistance "in corridor near M1". Subsequently, a staff PAB was brought to the hallway outside of bedroom #M1 and the ceiling sensor in the area detected the staff PAB, thereby cancelling the call made from resident #002 from within the Park Lane Lounge. The hallway outside of bedroom #M1, where the call was cancelled, was not the point of activation. The system does not allow calls to be cancelled only at the point of activation.

7. The licensee has a history of non-compliance related to the resident-staff communication and response system. As a result of complaint inspection #2012_054133_0028, conducted June 26th – 28th 2012, two Compliance Orders (#901, #902) were issued, pursuant to O. Reg. 79/10, s.17 (1)(b) "Every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that is on at all times". As a result of follow up inspection #2012_054133_0041, conducted on October 10th and 11th, 2012, the two compliance orders were complied, but problems remained with the system. Ongoing issues were addressed in Compliance Order #001, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c). "Every licensee of a long term care home shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair". As a result of follow up inspection #2013_204133_0024, conducted on September 5th and 6th, 2013, Compliance Order #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. This ongoing non-compliance related to the resident-staff communication and response system presents a pattern of risk to the residents of the home. (133)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 14, 2014

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

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**Order # / Ordre no :** 002

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

**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 take measures to ensure that the home is equipped with a resident-staff communication and response system that clearly indicates when activated where the signal is coming from.

The licensee will include, but not be limited to, the following measures in their efforts to achieve compliance with O. Reg. 79/10, s. 17 (1) (f):

a) The licensee must install system sensors in any/all locations where they may be lacking, such as in the back corner of the Park Lane Dining Room/ Park Lane Lounge area, so that the system clearly indicates where signals from such locations are coming from.

b) The licensee will develop and implement a comprehensive resident Personal Alert Badge (PAB) testing program. All resident PABs are to be activated, within the resident's bedroom and washroom, and in all common areas throughout the home that the residents have access to, including, but not limited to, hallways, washrooms, lounges and activity rooms, in order to ensure that when a call is made from those areas, the system clearly indicates where the signal is coming from. This is to be done in tandem with the resident PAB testing program, as prescribed in Compliance Order #001, which will verify that the system allows calls to be cancelled only at the point of activation. Results of this testing program, and any/all corrective measures taken, such as the installation of new system sensors and the provision of new PABs, must be documented.

c) The licensee will ensure that all staff are re-instructed as to the importance of reporting any/all system anomalies that they may discover during the course of their duties, or that may be reported to them by residents/visitors and/or family members, in order to allow for immediate investigation and follow up. Staff will be educated as to the process they are to follow, immediately, upon any such reports.

d) The licensee will ensure that any/all reports of system anomalies and/or equipment malfunctions, and subsequent corrective actions, are documented. This comprehensive record, specific to the resident-staff communication and response system, will be maintained and reviewed at least quarterly, in order to detect any possible emerging trends. The date of the review and the name(s) of the person(s) who conduct the review will be documented.

**Grounds / Motifs :**

1. The home is equipped with a wireless resident-staff communication and response system (the system). All residents and all nursing staff are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. The system ceiling sensors, throughout the home, interface with these PABs, indicating the location of the person wearing the PAB when the system last sensed them. Every nursing staff member is required to wear their PAB at all times while on shift. The vast majority of residents wear their PABs at all times as their primary method to call for assistance, from anywhere within the building. As well, in every common area, and in all resident washrooms, there is a remote pull station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to incoming calls for assistance. Above all resident bedrooms and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station in that area. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, when the closest ceiling sensor detects their PAB, and this cancels the call for assistance and signals that a staff person is present and responding to the call.

2. The licensee has failed to comply with O. Reg. 79/10, s. 17(1)(f) in that the resident-staff communication and response system does not clearly indicate, when activated, where the signal is coming from. During the follow up inspection, the following evidence was found that illustrates ongoing concerns with regards to the system. This presents a pattern of risk to the residents of the home.

3. In the company of the Environmental Services Manager (ESM), on November 26th, 2013, the inspector asked resident #001 to make a call with the PAB they were wearing. The resident was sitting at a table within the Park Lane dining room, in the back corner area, and their PAB was clipped to their shirt, beneath a zip up fleece sweater. Resident #001 unzipped their outer top, took the PAB out and pressed the button to make a call. A call was made, however a PSW in the area, staff member #S100, showed the inspector that their pager indicated the call was coming from resident #001's bedroom, which is near the end of the Macassa care unit hallway. This is not where the signal was coming from; the resident's bedroom is roughly 50 ft. away from entrance to the dining room where resident #001 was. The inspector, the ESM and staff #S100 noted that the white dome light was illuminated above the resident's doorway, indicating a

call was being made from that bedroom. The system did not clearly indicate where the signal was coming from.

4. After working with resident #001, the ESM and the inspector asked resident #002 to make a call with the PAB they were wearing. Resident #002 was seated at the table next to where resident #001 had been seated, in the area that is formally referred to as the Park Lane Lounge. The Park Lane Dining Room and Park Lane Lounge are one continuous L shaped space. The resident had their PAB attached to their shirt, with a button up sweater overtop, which was not obscuring the PAB. Resident #002 pressed the button and made a call. Staff member #S100 showed the inspector that their pager indicated that resident #002 required assistance "in corridor near M1". This is not where the signal was coming from; bedroom #M1 is roughly 10-15 ft. from the entrance to the dining room. The system did not clearly indicate where the signal was coming from.

5. The inspector noted that there is no ceiling sensor within the back area of the Park Lane dining room/Park Lane Lounge. The ESM indicated that adding a ceiling sensor in this area would likely remedy the issues described above with resident #001 and resident # 002.

6. On November 27th, 2013, in the company of the ESM, resident #003's PAB was tested while they were in the hallway outside of bedroom #M7 in the Macassa care unit. The PSW who was with the resident, staff member #S101, showed the inspector their pager, which indicated that resident #003 was making a call from room 1109. The PSW stated that it is hard to know where this resident makes a call from, when they are outside of their bedroom, as it does not correspond to the resident's location. Other resident PABs tested in the Macassa care unit hallway accurately reflected the resident's location, and in fact as they moved along the hallway and their PAB was detected by the next sensor, this was reflected on the staff pagers. The actual location of room 1109 could not be determined. Staff member #S101 indicated this is the only resident that they know of whose PAB does not accurately reflect their location when they call from outside of their bedroom. The system did not clearly indicate where the signal was coming from.

7. On the evening of November 27th, 2013, the ESM, the Administrator and the inspector found system malfunctions in an identified bedroom in an identified care unit. Resident #004 and #005 share two identified bedrooms, room A and

B. The Administrator asked resident #004 , who was sitting in room A, to make a call with their PAB. Resident #004 pressed the PAB button and no call was made. The Administrator speculated this was a result of her standing in front of resident #004 when they pressed the PAB button, thereby interfering with the PAB signal. Before another attempt could be made, the resident moved quickly to the washroom. The system did detect their presence in the washroom, as seen on the staff pager. Several moments later, resident #004 and #005 left room A, and went up the hallway to the dining room, as it was dinner time. Resident #004 gave their PAB to the ESM for further testing. On the subsequent attempt, a call was registered when the ESM pressed the PAB button from within bedroom A, but it registered on the staff pager as originating from a bedroom up the hallway, room C, and the white dome light above room C illuminated. The Administrator programmed a new PAB for resident #004, but the new PAB could not produce a call that indicated it was from within room A. Resident #005's PAB was then brought to room A, and it did produce a call from within room A, illuminating the white dome light above the doorway, and registering on the staff pager accurately. The ESM proceeded to install a new ceiling sensor in room A. Resident # 004's PAB was tested again, from within room A, and it still produced a call registering from room C. As well, resident #005's PAB was tested again, and it now too produced a call registering from room C. This issue was not seen when the residents' badges were tested in the A/B bathroom or in room B. Resident #004 indicated to the ESM and to the inspector that they had reported to nursing staff that there may be a problem with their PAB, but did not specify to whom, when, or what exactly was said. The resident further indicated to the ESM and inspector that they been advised by staff to take their PAB out into the hallway as a corrective measure to the problem they reported. The system did not clearly indicate where the signal was coming from.

8. The licensee has a history of non-compliance related to the resident-staff communication and response system. As a result of complaint inspection #2012_054133_0028, conducted June 26th – 28th 2012, two Compliance Orders (#901, #902) were issued, pursuant to O. Reg. 79/10, s.17 (1)(b) "Every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that is on at all times". As a result of follow up inspection #2012_054133_0041, conducted on October 10th and 11th, 2012, the two compliance orders were complied, but problems remained with the system. Ongoing issues were addressed in Compliance Order #001, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c). "Every licensee of a

long term care home shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair". As a result of follow up inspection #2013_204133_0024, conducted on September 5th and 6th, 2013, Compliance Order #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. This ongoing non-compliance related to the resident-staff communication and response system presents a pattern of risk to the residents of the home. (133)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 14, 2014

**Order # / Ordre no :** 003

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

**Linked to Existing Order / Lien vers ordre existant:** 2013_204133_0024, CO #001;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

**Order / Ordre :**

The licensee shall take measures to ensure that the resident-staff communication and response system within the home, which includes Personal Alert Badges (PABs) and remote stations in all areas of the home, is maintained in a good state of repair. The licensee will ensure that, at all times and in all locations, the system is working in a consistent manner and may be used by residents, staff and visitors to call for assistance.

The licensee will include, but not be limited to, the following measures in their efforts to achieve compliance with LTCHA, 2007, S.O. 2007, c.8, s.15 (2) (c):

a) The licensee will ensure that a sufficient supply of required equipment, such as Radio Frequency Antennas (RFAs), PABs, and system sensors, are kept in house to allow for the immediate repair of malfunctioning equipment.

b) The licensee will increase the frequency of testing of the remote stations, which is currently done once a month, to at a minimum of weekly, to ensure that malfunctioning equipment is detected and repaired/replaced in a timelier manner.

c) The licensee will increase the frequency of diagnostic report reviews, such as the "low badge battery" system report, which is currently done once per day, to

twice per day, and will take immediate action as required.

d) The licensee will ensure that the documented PAB testing, done on the day and evening shift by Personal Support Workers, is reviewed, by a person other than those that conducted the testing, following completion of the testing. The reviewer will ensure that the information that is presented on the system computer console, at the nurse station desks, corresponds with what is documented. For example, that the time the PAB was tested by the PSWs corresponds, generally, to what is indicated by the system. As well, the reviewer will ensure that any equipment failure documented by the PSW's, such as a dome light that did not illuminate when the PAB was tested, is immediately reported to the maintenance staff, to allow for timely follow up and repair. The Assistant Director of Care and/or the Administrator will review the documented PAB testing at least weekly, and will coordinate with the Maintenance Manager to ensure that any malfunctioning equipment that was documented by the PSWs has been reported and subsequently repaired.

e) The licensee will ensure that when the system computer console, at the nurse stations, shows a lightning bolt next to a residents name, the PAB battery will be replaced, as opposed to waiting for the PAB to fail. This lightning symbol indicates that battery failure will occur over the next several days, depending on the frequency of use of the PAB.

f) The licensee will ensure that, for every resident PAB, a documented record of battery changes is maintained. Daily diagnostic reports, such as the low badge battery reports, will be printed and kept with this record.

g) The licensee will ensure that follow up to any resident or family/visitor complaint related to length of response time to a call made from a PAB or remote station includes testing of the PAB and or remote station, several times in close proximity, and then periodically over the course of a 24 hour period. This testing will be done by the Registered Nursing staff and/or by Management staff, and will be documented.

h) The licensee will ensure that all staff are re-instructed as to the importance of reporting any/all system anomalies that they may discover during the course of their duties, or that may be reported to them by residents/visitors and/or family members, in order to allow for immediate investigation and follow up. Staff will be educated as to the process they are to follow, immediately, upon any such

reports.

i) The licensee will develop and implement written policies and procedures that capture all of the above, and any other interventions that the licensee implements, in an effort to ensure the resident-staff communication and response system is maintained in a good state of repair, can be used at all times and in all locations, by residents, staff and visitors to call for assistance, and is compliant with O. Reg. 79/10, s.17.(1) in its entirety. All current staff will be made aware of these new policies and procedures. These policies and procedures will be incorporated into the home's orientation program, as well as into the home's annual retraining program.

**Grounds / Motifs :**

1. The home is equipped with a wireless resident-staff communication and response system (the system). All residents and all nursing staff are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. The system ceiling sensors, throughout the home, interface with these PABs, indicating the location of the person wearing the PAB when the system last sensed them. Every nursing staff member is required to wear their PAB at all times while on shift. The vast majority of residents wear their PABs at all times as their primary method to call for assistance, from anywhere within the building. As well, in every common area, and in all resident washrooms, there is a remote pull station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to incoming calls for assistance. Above all resident bedrooms and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station in that area. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, when the closest ceiling sensor detects their PAB, and this cancels the call for assistance and signals that a staff person is present and responding to the call.

2. The licensee has failed to comply with to LTCHA, 2007, S.O. 2007, c.8, s.15. (2)(c) in that the licensee has failed to ensure that the resident-staff communication and response system, which includes the components discussed above, is in a good state of repair. During the follow up inspection, the following evidence was found that demonstrates that the system is not working consistently and reliably. This presents a pattern of risk to the residents of the

home.

3. On November 26, 2013, the inspector worked in collaboration with the Environmental Services Manager (ESM) and the maintenance aid, and a full audit of the remote call stations in resident bedrooms and common areas was conducted. The remote station in the bathroom for bedroom S9, in the Sylvanite Avenue care unit, did not produce a call when tested. Later that day, the remote station was replaced with a newer model by the ESM, and this new unit produced a call when tested by the inspector on November 27th 2013. The monthly testing procedure for remote stations had occurred the week before, and this equipment malfunction had not been picked up then. The remote station in the bathroom for bedroom L9, within the Lakeshore care unit, did not produce a call the 1st time it was tested, it did produce a call the 2nd time it was tested, it did not produce a call the 3rd time it was tested, and it did produce a call the 4th time it was tested. The remote station in shower room #2034, within the Lakeshore care unit, at the toilet, tested similarly to the remote station in L9 (as above). The remote station in the tub room, next to the shower room, within the Lakeshore care unit, at the toilet, did not produce a call the 1st time it was tested but did produce a call the 2nd and 3rd time it was tested. The ESM indicated this was all related to a malfunctioning Radio Frequency Antenna (RFA) in the hallway within the immediate area of L9, the shower room and the tub room, which had been picked up the week before during the monthly testing process. A new RFA was on order at the time, was received and installed, by maintenance staff, on November 27th, and the 3 malfunctioning remote stations in the Lakeshore care unit produced calls consistently when tested by the inspector on that day. The equipment noted above was not in a good state of repair when initially tested by the inspector.

4. In the company of the ESM, on November 26th, 2013, at 3:28pm, the inspector noted that the system computer console at the Kirkland nurse station indicated that the system had not detected resident #006's PAB since November 25th, 2013, at 6:02pm. The inspector and ESM progressed to the resident's bedroom, #W9, within the Wright Hargreaves care unit, and found the bedroom door wide open, and the resident sleeping, however their PAB was visible to the inspector, on the bedside table. The inspector entered the room and pressed the PAB button. The ESM confirmed that the white dome light did not illuminate above the doorway, and that there was no call reflected on the system computer console at the Kirkland nurse station. At 7pm, on November 26th, the inspector returned to see resident #006 in order to test the PAB again. The resident

pressed the PAB button, and again there was no white dome light illuminated above the doorway. The inspector confirmed with the two PSWs working on the care unit, staff member #S102 and #S103, that they did not receive a call from resident #006 to their pagers. This piece of equipment, resident #006's PAB, was not in a good state of repair when tested by the inspector.

5. The licensee has a history of non-compliance related to the resident-staff communication and response system. As a result of complaint inspection #2012_054133_0028, conducted June 26th – 28th 2012, two Compliance Orders (#901, #902) were issued, pursuant to O. Reg. 79/10, s.17 (1)(b) "Every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that is on at all times". As a result of follow up inspection #2012_054133_0041, conducted on October 10th and 11th, 2012, the two compliance orders were complied, but problems remained with the system. Ongoing issues were addressed in Compliance Order #001, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c). "Every licensee of a long term care home shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair". As a result of follow up inspection #2013_204133_0024, conducted on September 5th and 6th, 2013, Compliance Order #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. This ongoing non-compliance related to the resident-staff communication and response system presents a pattern of risk to the residents of the home. (133)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 14, 2014

## 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
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 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
Performance Improvement and Compliance 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 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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.

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

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 13th day of December, 2013**

**Signature of Inspector / Signature de l'inspecteur :** Jessica Lapensée

**Name of Inspector / Nom de l'inspecteur :** JESSICA LAPENSEE

**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**

**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**


**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 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 13, 2013 | 2013_304133_0033 | S-00388-13 | Follow up |

**Licensee/Titulaire de permis**

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4

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

JESSICA LAPENSEE (133)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): November 26th-28th, 2013**

**During the course of the inspection, the inspector(s) spoke with The Administrator/Director of Care, the Assistant Director of Care, the Environmental Services Manager, the Maintenance Assistant, Registered and Non Registered nursing staff, the lead hand for housekeeping services, and residents.**

**During the course of the inspection, the inspector(s) verified the operation of various components of the resident-staff communication and response system.**

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

**Safe and Secure Home**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 17. Communication and response system**

**Specifically failed to comply with the following:**

**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; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(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. The home is equipped with a wireless resident-staff communication and response system (the system). All residents and all nursing staff are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. The system ceiling sensors, throughout the home, interface with these PABs, indicating the location of the person wearing the PAB when the system last sensed them. Every nursing staff member is required to wear their PAB at all times while on shift. The vast majority of residents wear their PABs at all times as their primary method to call for assistance, from anywhere within the building. As well, in every common area and in all resident washrooms, there is a remote pull station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to incoming calls for assistance. Above all resident bedrooms and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station in that area. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, when the closest ceiling sensor detects their PAB, and this cancels the call for assistance and signals that a staff person is present and responding to the call.

The licensee has failed to comply with O. Reg. 79/10, s. 17.(1)(c) in that the home is not equipped with a resident-staff communication and response system that allows

calls to be cancelled only at the point of activation. During the follow up inspection, the following evidence was found that illustrates ongoing concerns with regards to the system. This presents a widespread pattern of risk to the residents of the home.

In the company of the Environmental Services Manager (ESM), on November 26th and 27th, 2013, the inspector noted that in private bedrooms with a private bathroom, and in rooms with 2 beds and a bathroom, referred to as ward rooms by the home, there are no system ceiling sensors in the bathrooms. If a call is made from a resident PAB or from a remote call station on the wall next to the toilet in these bathrooms, the call can be cancelled without going into the bathroom. Once the bedroom ceiling sensor detects the staff PAB, the call is cancelled. Staff do not have to go to the point of activation, which is in the bathroom, in order to cancel a call originating from that location in these 2 types of bedrooms. The lead hand for housekeeping services informed the inspector that there are 39 such bedrooms in the home, affecting 53 of 81 residents. The system does not allow calls to be cancelled only at the point of activation.

In addition to the above, in the company of the ESM, on November 27th, 2013, the inspector noted that calls made from a resident PAB, from within a bedroom, can be cancelled from outside of a bedroom. This was first observed in bedrooms in the Lakeshore care unit, #L7, #L3, #L4, #L9, #L2. Wearing a staff PAB, the inspector was able to activate the green dome light above the bedroom doorways, and thereby cancel the call, while standing in the hallway. The bedroom ceiling sensors were able to detect the staff PAB from the hallway, given the location of the sensors. The distance varied, from several inches from the entrance, up to approximately 2 ft. from the entrance to the bedroom. Considering both issues together, in bedrooms #L3 and #L2, for example, the inspector was able to cancel a call originating from the private bathroom without entering the bedroom. Following this discovery, the maintenance assistant began moving ceiling sensors, which are within ceiling tiles, deeper into the bedrooms, which appeared to resolve the issue of calls being cancelled from the hallway. This was observed by the inspector in #L2, #L4 and #L9. This does not resolve the issue of calls from private washrooms being cancelled from within the bedroom, without having to enter the bathroom. The system does not allow calls to be cancelled only at the point of activation.

In the company of the ESM, on November 26th, 2013, the inspector asked resident #001 to make a call with the PAB they were wearing. The resident was sitting at a table within the Park Lane dining room, in the back corner area, and their PAB was

clipped to their shirt, beneath a zip up fleece sweater. Resident #001 unzipped their outer top, took the PAB out and pressed the button to make a call. A call was made, however a PSW in the area, staff member #S100, showed the inspector that their pager indicated the call was coming from resident #001's bedroom, which is near the end of the Macassa care unit hallway. The inspector, the ESM and staff #S100 noted that the white dome light was illuminated above the resident's bedroom doorway, indicating a call was being made from that bedroom. In order to cancel the call made by resident #001 in the dining room, the ESM had to take a staff PAB down the Macassa unit hallway, to the resident's bedroom. The ESM entered the bedroom, the ceiling sensors detected the staff PAB, the green dome light illuminated and the white dome light turned off. The resident's bedroom, where the call was cancelled, was not the point of activation. The system does not allow calls to be cancelled only at the point of activation.

After working with resident #001, the ESM and the inspector asked resident #002 to make a call with the PAB they were wearing. Resident #002 was seated at the table next to where resident #001 had been seated, in the area that is formally referred to as the Park Lane Lounge. The Park Lane Dining Room and Park Lane Lounge are one continuous L shaped space. The resident had their PAB attached to their shirt, with a button up sweater overtop, which was not obscuring the PAB. Resident #002 pressed the button and made a call. Staff member #S100 showed the inspector that their pager indicated that resident #002 required assistance "in corridor near M1". Subsequently, a staff PAB was brought to the hallway outside of bedroom #M1 and the ceiling sensor in the area detected the staff PAB, thereby cancelling the call made from resident #002 from within the Park Lane Lounge. The hallway outside of bedroom #M1, where the call was cancelled, was not the point of activation. The system does not allow calls to be cancelled only at the point of activation. [s. 17. (1) (c)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 17(1)f. in that the resident-staff communication and response system does not clearly indicate, when activated, where the signal is coming from. During the follow up inspection, the following evidence was found that illustrates ongoing concerns with regards to the system. This presents a pattern of risk to the residents of the home.

In the company of the Environmental Services Manager (ESM), on November 26th, 2013, the inspector asked resident #001 to make a call with the PAB they were wearing. The resident was sitting at a table within the Park Lane dining room, in the

back corner area, and their PAB was clipped to their shirt, beneath a zip up fleece sweater. Resident #001 unzipped their outer top, took the PAB out and pressed the button to make a call. A call was made, however a PSW in the area, staff member #S100, showed the inspector that their pager indicated the call was coming from resident #001's bedroom, which is near the end of the Macassa care unit hallway. This is not where the signal was coming from; the resident's bedroom is roughly 50 ft. away from entrance to the dining room where resident #001 was. The inspector, the ESM and staff #S100 noted that the white dome light was illuminated above the resident's bedroom doorway, indicating a call was being made from that bedroom. The system did not clearly indicate where the signal was coming from.

After working with resident #001, the ESM and the inspector asked resident #002 to make a call with the PAB they were wearing. Resident #002 was seated at the table next to where resident #001 had been seated, in the area that is formally referred to as the Park Lane Lounge. The Park Lane Dining Room and Park Lane Lounge are one continuous L shaped space. The resident had their PAB attached to their shirt, with a button up sweater overtop, which was not obscuring the PAB. Resident #002 pressed the button and made a call. Staff member #S100 showed the inspector that their pager indicated that resident #002 required assistance "in corridor near M1". This is not where the signal was coming from; bedroom #M1 is roughly 10-15 ft. from the entrance to the dining room. The system did not clearly indicate where the signal was coming from.

The inspector noted that there is no ceiling sensor within the back area of the Park Lane dining room/Park Lane Lounge. The ESM indicated that adding a ceiling sensor in this area would likely remedy the issues described above with resident #001 and resident #002.

On November 27th, 2013, in the company of the ESM, resident #003's PAB was tested while they were in the hallway outside of bedroom #M7 in the Macassa care unit. The PSW who was with the resident, staff member #S101, showed the inspector their pager, which indicated that resident #003 was making a call from room 1109. The PSW stated that it is hard to know where this resident makes a call from, when they are outside of their bedroom, as it does not correspond to the resident's location. Other resident PABs tested in the Macassa care unit hallway accurately reflected the resident's location, and in fact as they moved along the hallway and their PAB was detected by the next sensor, this was reflected on the staff pagers. The actual location of room 1109 could not be determined. Staff member #S101 indicated this is

the only resident that they know of whose PAB does not accurately reflect their location when they call from outside of their bedroom. The system did not clearly indicate where the signal was coming from.

On the evening of November 27th, 2013, the ESM, the Administrator and the inspector found system malfunctions in an identified bedroom in an identified care unit. Resident #004 and #005 share two identified bedrooms, room A and B. The Administrator asked resident #004, who was sitting in room A, to make a call with their PAB. Resident #004 pressed the PAB button and no call was made. The Administrator speculated this was a result of her standing in front of resident #004 when they pressed the PAB button, thereby interfering with the PAB signal. Before another attempt could be made, the resident moved quickly to the washroom. The system did detect their presence in the washroom, as seen on the staff pager. Several moments later, resident #004 and #005 left room A, and went up the hallway to the dining room, as it was dinner time. Resident #004 gave their PAB to the ESM for further testing. On the subsequent attempt, a call was registered when the ESM pressed the PAB button from within room A, but it registered on the staff pager as originating from an identified bedroom up the hallway, room C, and the white dome light above room C illuminated. The Administrator programmed a new PAB for resident #004, but the new PAB could not produce a call that indicated it was from within room A. Resident #005's PAB was then brought to room A, and it did produce a call from within room A, illuminating the white dome light above the doorway, and registering on the staff pager accurately. The ESM proceeded to install a new ceiling sensor in room A. Resident # 004's PAB was tested again, from within room A, and it still produced a call registering from room C. As well, resident #005's PAB was tested again, and it now too produced a call registering from room C. This issue was not seen when the residents' badges were tested in the room A/B bathroom or in room B. Resident #004 indicated to the ESM and to the inspector that they had reported to nursing staff that there may be a problem with their PAB, but did not specify to whom, when, or what exactly was said. The resident further indicated to the ESM and inspector that they been advised by staff to take their PAB out into the hallway as a corrective measure to the problem they reported. The system did not clearly indicate where the signal was coming from.

The licensee has a history of non-compliance related to the resident-staff communication and response system. As a result of complaint inspection #2012_054133_0028, conducted June 26th – 28th 2012, two Compliance Orders (#901, #902) were issued, pursuant to O. Reg. 79/10, s.17 (1)(b) "Every licensee of a

long term care home shall ensure that the home is equipped with a resident-staff communication and response system that is on at all times". As a result of follow up inspection #2012_054133_0041, conducted on October 10th and 11th, 2012, the two compliance orders were complied, but problems remained with the system. Ongoing issues were addressed in Compliance Order #001, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c). "Every licensee of a long term care home shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair". As a result of follow up inspection #2013_204133_0024, conducted on September 5th and 6th, 2013, Compliance Order #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. This ongoing non-compliance related to the resident-staff communication and response system presents a pattern of risk to the residents of the home. [s. 17. (1) (f)]

***Additional Required Actions:***

***CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

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**Findings/Faits saillants :**

1. The home is equipped with a wireless resident-staff communication and response system (the system). All residents and all nursing staff are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. The system ceiling sensors, throughout the home, interface with these PABs, indicating the location of the person wearing the PAB when the system last sensed them. Every nursing staff member is required to wear their PAB at all times while on shift. The vast majority of residents wear their PABs at all times as their

primary method to call for assistance, from anywhere within the building. As well, in every common area, and in all resident washrooms, there is a remote pull station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to incoming calls for assistance. Above all resident bedrooms and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station in that area. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, when the closest ceiling sensor detects their PAB, and this cancels the call for assistance and signals that a staff person is present and responding to the call.

2. The licensee has failed to comply with to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c) in that the licensee has failed to ensure that the resident-staff communication and response system, which includes the components discussed above, is in a good state of repair. During the follow up inspection, the following evidence was found that demonstrates that the system is not working consistently and reliably. This presents a pattern of risk to the residents of the home.

3. On November 26, 2013, the inspector worked in collaboration with the Environmental Services Manager (ESM) and the maintenance aid, and a full audit of the remote call stations in resident bedrooms and common areas was conducted. The remote station in the bathroom for bedroom S9, in the Sylvanite Avenue care unit, did not produce a call when tested. Later that day, the remote station was replaced with a newer model by the ESM, and this new unit produced a call when tested by the inspector on November 27th 2013. The monthly testing procedure for remote stations had occurred the week before, and this equipment malfunction had not been picked up then. The remote station in the bathroom for bedroom L9, within the Lakeshore care unit, did not produce a call the 1st time it was tested, it did produce a call the 2nd time it was tested, it did not produce a call the 3rd time it was tested, and it did produce a call the 4th time it was tested. The remote station in shower room #2034, within the Lakeshore care unit, at the toilet, tested similarly to the remote station in L9 (as above). The remote station in the tub room, next to the shower room, within the Lakeshore care unit, at the toilet, did not produce a call the 1st time it was tested but did produce a call the 2nd and 3rd time it was tested. The ESM indicated this was all related to a malfunctioning Radio Frequency Antenna (RFA) in the hallway within the immediate area of L9, the shower room and the tub room, which had been picked up the week before during the monthly testing process. A new RFA was on order at the

time, was received and installed, by maintenance staff, on November 27th, and the 3 malfunctioning remote stations in the Lakeshore care unit produced calls consistently when tested by the inspector on that day. The equipment noted above was not in a good state of repair when initially tested by the inspector.

4. In the company of the ESM, on November 26th, 2013, at 3:28pm, the inspector noted that the system computer console at the Kirkland nurse station indicated that the system had not detected resident #006's PAB since November 25th, 2013, at 6:02pm. The inspector and ESM progressed to the resident's bedroom, and found the bedroom door wide open, and the resident sleeping, however their PAB was visible to the inspector, on the bedside table. The inspector entered the room and pressed the PAB button. The ESM confirmed that the white dome light did not illuminate above the doorway, and that there was no call reflected on the system computer console at the Kirkland nurse station. At 7pm, on November 26th, the inspector returned to see resident #006 in order to test the PAB again. The resident pressed the PAB button, and again there was no white dome light illuminated above the doorway. The inspector confirmed with the two PSWs working on the care unit, staff member #S102 and #S103, that they did not receive a call from resident #006 to their pagers. This piece of equipment, resident #006's PAB, was not in a good state of repair when tested by the inspector.

5. The licensee has a history of non-compliance related to the resident-staff communication and response system. As a result of complaint inspection #2012_054133_0028, conducted June 26th – 28th 2012, two Compliance Orders (#901, #902) were issued, pursuant to O. Reg. 79/10, s.17 (1)(b) "Every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that is on at all times". As a result of follow up inspection #2012_054133_0041, conducted on October 10th and 11th, 2012, the two compliance orders were complied, but problems remained with the system. Ongoing issues were addressed in Compliance Order #001, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c). "Every licensee of a long term care home shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair". As a result of follow up inspection #2013_204133_0024, conducted on September 5th and 6th, 2013, Compliance Order #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. This ongoing non-compliance related to the resident-staff communication and response system presents a pattern of risk to the residents of the home. [s. 15. (2) (c)]

***Additional Required Actions:***

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

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**Issued on this 13th day of December, 2013**

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

Jessica Lapensée