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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 20, 2015	2015_285546_0005	O-001545-15	Resident Quality Inspection

Licensee/Titulaire de permis

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street Clarence Creek ON K0A 1N0

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

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street Clarence Creek ON K0A 1N0

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

SUSAN WENDT (546), JOANNE HENRIE (550), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 2, 3, 4, 5, 6, 9, 10, 2015

in addition to inspecting Log O-001402-14 for a critical incident

During the course of the inspection, the inspector(s) spoke with Residents, Family members, the President of the Residents' Council, the Administrator, the Director of Care, the assistant Director of Care (ADOC), the RAI Coordinator, the Administrative Technician, the Food Service Supervisor, the Environmental Manager, Housekeeping aides, dietary aides, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), one Physiotherapist.

In addition, the Inspectors toured residential and non residential areas, observed resident care, observed meal and snack services, reviewed several of the home's policies and procedures, observed a medication pass including medication room, observed recreation activities, observed physiotherapy treatments, reviewed minutes for Residents' Council, reviewed the Satisfaction Survey documents, reviewed Resident Health Care records, including plans of care, medication and treatment records and PSW Point of Care documentation, reviewed the activity calendars, reviewed staffing schedules, reviewed food service documentation, including menus and a critical incident report.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

- **8 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 licensee failed to comply with O. Reg 79/10, r. 17 (1) (g) in that every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
* 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.

It was determined that the Home uses a resident-staff communication system, commonly referred to as a call bell system, in which a person (resident, staff or visitor) in any resident's room can send a signal for assistance by engaging a button on a cord attached to a call bell station; in the resident's washroom or the tub/shower room, a person (resident, staff or visitor) can pull a call bell pull cord that engages the pull station of a call bell to send a signal. Once engaged, the signal for the call bell system activates a light outside the door of the resident's room, and an audible alarm, along with a location display on a panel at the central nursing station, sounds. The Home does not use a pager system linked into the call bell system. The layout of the Home's wings does not favor good viewing of residents' lights outside the rooms or down a corridor.

The Home's call bell system, which uses sound to alert staff, only emanates from the central nursing station on the first floor (or the second floor, if engaged from a second

floor room). However, when the doors to the first floor's special care dementia unit are closed and secured, there is no audible sound within the C-100 wing's mid to end of hallway to alert staff of an active call emanating from residents' rooms, toilets and tub/shower rooms. In addition, there is no audible sound within the D-100 wing's hallway of the first floor and, there is no audible sound within the C-200 and D-200 wings' hallways of the second floor, specifically from mid to end of hallways in those identified wings.

During this inspection, Inspector #546 verified the call bell system in the secured access dementia wing on the first floor. When activating a call, by pressing the button at the console in the residents' rooms, specifically for rooms 101, 102, 105, 107, 110, 111, 112 and 114, or by pulling the cord, pressing the call-bell in the toilets and tub/shower room, there was no audible sound within the hallway of the C-100 wing of the first floor. When interviewed by the Inspector, the PSW staff on the secured unit reported relying on the lights outside the rooms in the corridor.

Equally during this inspection, Inspector #126 reported that when activating a call from residents' rooms, specifically rooms 126, 127, 128, 130 and 132, there was no audible sound within the hallway of the D-100 wing of the first floor. In addition, Inspector #550 also reported that when activating a call from residents' rooms, specifically rooms 210, 227, 228, 229 and 231, there was no audible sound within the hallway of the C-200 and D-200 wings of the second floor.

It must be noted that a resident-staff communication and response system is required in those identified areas for use by residents, as per O. Reg. 79/10, s.17 (1) (e). The fact that only residents may be in those certain areas, it does not negate the need for audible sound availability for all staff, especially when the staff ratio is reduced on evenings and nights. The lack of audible sound availability from the call bell system, identified in those areas, accessed by residents, staff or visitors, is a potential risk to the health, safety and comfort and well-being of residents who may not be able to call or have calls placed for assistance by staff or visitors.

This area of non-compliance was issued as a voluntary plan of correction during the May 2014 RQI. The Administrator informed the Inspector that although the communication and response system was reviewed by a technician, it was not corrected due to costs. As of the exit date of this inspection, there was no audible sound within the hallway of the secured unit and from the rooms noted above. [s. 17. (1) (g)]

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Home's program for falls meet the requirements, as per O.Reg 79/10 s. 30. (1) 1.

On February 5, 2015, the Director of Care (DOC) gave Inspector #550 a copy of the Home's Falls Prevention Program (issued May 2005, revised July 2007, May 2009 and August 2013). The document described generic goals, definitions and guiding principles, along with causes for falls; the document included guidelines to assess, intrinsic and extrinsic factors related to falls, a falls risk assessment form.

In an interview with the DOC on February 9, 2015, Inspectors #546 and #550 requested a copy of the policies and procedures associated with the Falls Prevention Program.

In a discussion with the Inspectors on February 10, 2015, the Administrator confirmed there were no policies or procedures related to the Falls Prevention Program.

On February 10, 2015, during a discussion with Inspectors #546 and #550, the DOC confirmed that the document provided on February 5, 2015, did not have policies or procedures for it and that the document was more of a conceptual framework rather than a program for falls prevention and management. The DOC confirmed that the program had not been developed with relevant policies, procedures, protocols and methods to monitor outcomes.

As such, policies, procedures, protocols and methods to monitor outcomes have not been developed for the falls prevention and management program, therefore, the licensee does not comply with the Act. [s. 30. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee develop policies, procedures and means to monitor outcomes related to falls prevention and management. This plan should also include an educational component that ensures that all staff receives training in respect to the revised falls prevention and management program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when a resident falls, the staff assesses the resident and that where the condition or circumstances of the resident require, that the staff uses its post-fall assessment tool.

During a Staff Interview conducted by Inspector #546 on February 3, 2015, RN S#101 indicated that a specific resident had recently fallen on January 29, 2015 and on February 2, 2015, but had not sustained any injuries.

Upon review of the electronic documentation, Inspector #546 observed progress notes for eight (8) falls sustained by the specific Resident between the period of July 2014 to February 2015; of the eight falls, three (3) electronic post-fall assessments were completed, 1 was incomplete and 3 were not completed.

In the presence of the inspector on February 9, 2015, when S#101 reviewed the resident's electronic records to retrieve the post fall assessments for this resident, she observed and reported that some post-fall assessments were not completed; one was incomplete. When asked what the protocol was in regards to falls sustained by residents, S#101 replied that the expectation was for all registered staff to complete a post-fall assessment following a fall, whether there are injuries or no injuries sustained.

In an interview with the Inspectors, the DOC confirmed that the expectation was for all registered staff to complete a post-fall assessment following a fall, whether there were injuries or no injuries sustained and that if the documentation was not in the electronic record, the post-fall assessments were not done.

Therefore, the post-fall assessment process is not conducted or applied consistently when a resident has fallen. [s. 49. (2)]

2. The licensee has failed to ensure that when the resident has fallen, that the resident be assessed and, if required, a post-fall assessment be conducted using a clinically appropriate assessment instrument, that is specifically designed for falls.

During a staff interview, S#104 indicated to Inspector #550 that a specific resident was found on his/her knees beside his/her bed on a specific night in February 2015 and has a result of this, the resident sustained an abrasion to the left knee.

The resident indicated to Inspector #550 that during that specific night in February 2015, he/she fell to the floor when returning to his/her bed from the washroom. He/She attempted to climb back to bed, missed the bed and fell to his/her knees. He/She indicated to inspector he/she was wearing his/her socks and there was no light in the room.

Inspector #550 reviewed the resident's health records and was able to find a post fall assessment in Medecare but the assessment was not completed.

S#104 indicated to Inspector #550 that when a resident has a fall, a post fall assessment is conducted and kept in Medecare. She reviewed the specific resident's electronic records to retrieve the post fall assessment for this resident for his fall on the specific date in February 2015 and she observed it was not completed, therefore no other interventions were put in place to prevent the resident from falling.

During an interview, the Director of Care indicated to the inspector that whenever a resident has a fall, the registered staff must conduct a post fall assessment. These assessments are kept in the resident's electronic records in Medecare. She indicated to Inspector #550 a post fall assessment was not completed for the specific resident for his fall in February 2015 as the registered staff did not enter the fall as a fall incident in the progress notes. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, when residents fall, residents are assessed and that where the condition or circumstances of the resident require the staff use the Home's clinically appropriate post-fall assessment tool in a consistent manner, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57 (2) in that the Licensee does not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During a review of Residents' Council minutes for the year 2014, the following indicated
* for the meeting held on April 2, 2014 - the response from the Administrator is dated as May 12, 2014;
* for the meeting held on June 4, 2014 - the response from the Administrator is dated as June 26, 2014;
* for the meeting held on August 6, 2014 - the response from the Administrator is dated as August 29, 2014;
* for the meeting held on October 9, 2014 - the response from the Administrator is dated as October 21, 2014;
* for the meeting of December 3, 2014 - the response from the Administrator is dated as December 16, 2014.

At the time of this RQI, there were no Residents' Council minutes for 2015. A Residents' Council meeting was held on February 4, 2015.

During an interview with Inspector #546 on February 4, 2015, the Administrator confirmed that his written response to Residents' Council's minutes had been inconsistent and delayed and that a special effort would be made to ensure compliance. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee duly responds in writing, within the Act's specified 10 days of receipt of the Residents' Council advice, concerns and recommendations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart:

ii. that is secure and locked.

On the morning of February 5, 2015, Inspector #550 observed S#106 administering a medication by inhalation to a specific resident, taken from the resident's bedside table; the bedside table's 2nd drawer was not locked. S#106 indicated to the inspector that the resident kept the puffer at the bedside but never self-administered. The specific resident who lives with his/her spouse in the same room, indicated and showed Inspector #550 that the spouse also had a puffer that was kept in the 2nd drawer of the bedside table, which was also not locked.

At the time of the observation, Inspector #550 observed that the lock on the 3rd drawer of the specific resident's bedside table was not functioning. Following the observation, during an interview, S#104 indicated that all residents who kept medication at their bedside must keep them in the 3rd drawer of their bedside table, as it is the only drawer that had a lock; she was unaware these residents did not keep their medication locked.

The Director of Care indicated to Inspector #550 that she was not aware that the identified residents kept medications at their bedside and that all residents who kept medication at their bedside were required to keep them in a locked area at all times. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents, permitted to keep medications in their room, shall keep the medications in a locked area at all times., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview with Inspector #550, a specific resident indicated receiving a complete bath once a week on Saturdays, while most of the other residents received a complete bath two times per week.

S#110 indicated to Inspector #550 that the specific resident was scheduled to have a complete bath twice a week, on Wednesdays and Saturdays, as per the Home's bathing schedule. S#110 indicated they document the complete baths in Medecare.

During an interview, the Director of Care indicated to Inspector #550 that it is the Home's expectation that all residents receive a complete bath or a shower or a sponge bath twice a week and that PSWs were to document this in Medecare, even if the resident refused. After reviewing the documentation by PSWs in Medecare, the Director of Care indicated

she did not know why the specific resident did not receive a bath twice per week. The DOC confirmed that if the bath was not documented, it was not done.

Inspector #550 observed the documentation in the flow sheets for bathing in Medecare for the specific resident from November 2nd, 2014 to February 6th, 2015. During the 13 weeks' period, the resident received a complete bath as indicated:

-for the week of November 2-8, 2014: on November 8
-for the week of November 9-15, 2014: on November 15
-for the week of November 16-22, 2014: on November 22
-for the week of November 23-29, 2014: no baths
-for the week of November 30-December 6, 2014: on December 6
-for the week of December 7-13, 2014: no baths
-for the week of December 14-20, 2014: on December 20
-for the week of December 21-27, 2014: on December 27
-for the week of December 28, 2014-January 3, 2015: no baths
-for the week of January 4-10, 2015: no baths
-for the week of January 11-17, 2015: on January 14
-for the week of January 18-24, 2015: no baths
-for the week of January 25-31, 2015: on January 31

There was no documentation indicating that the resident had refused a bath.

During the 13 weeks of documentation observed by Inspector #550, the specific resident received eight (8) complete baths, when the resident should have received a total of twenty-six (26) baths. [s. 33. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

During the observation of the lunch dining service in the secured unit's dining room on February 2, 2015, Inspector #550 observed that the weekly menu was not posted in the dining room, but posted inside the servery and out of the residents' view. This location is not accessible to residents, therefore, the weekly menu was not communicated to the residents.

During an interview, the Food Service Supervisor indicated to the inspector that the weekly menu was not posted in the secured unit's dining room because there was no bulletin board where she could post the menu. She indicated if the residents or family members wanted to see the menu they could go to the other dining rooms in the home where the weekly menu was posted. [s. 73. (1) 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that quarterly itemized statements are provided to the resident, or to a person acting on behalf of a resident respecting money held by the licensee in trust for the resident, that include:

* deposits
* withdrawals, and
* the balance of the resident's funds as of the date of the statement.

During a family interview, Inspector #550 was apprised by a specific resident's family that no statements were issued for trust accounts.

On February 5, 2015, the Administrative Technician indicated to Inspector #550 during an interview that the Home did not send out any itemized statements to the residents or to a person acting on behalf of the resident. The resident was informed of the account balance whenever they requested it.

During an interview, the Administrator indicated to Inspector #550 that the Home did not send out any statements to the residents of their trust account. [s. 241. (7) (f)]

Issued on this 6th day of March, 2015

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

Original report signed by the inspector.

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN WENDT (546), JOANNE HENRIE (550), LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2015_285546_0005
Log No. / Registre no:	O-001545-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 20, 2015
Licensee / Titulaire de permis :	CENTRE D'ACCUEIL ROGER SEGUIN 435 Lemay Street, Clarence Creek, ON, K0A-1N0
LTC Home / Foyer de SLD :	CENTRE D'ACCUEIL ROGER SEGUIN 435 Lemay Street, Clarence Creek, ON, K0A-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHARLES LEFEBVRE

To CENTRE D'ACCUEIL ROGER SEGUIN, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

In order to achieve compliance with O. Reg. 79/10, s. 17 (1) (g), the licensee shall ensure that:

1) the resident-staff communication and response system, serving the Home's four (4) wings is properly calibrated so that the level of sound is audible to the staff working in those identified wings; and,

2) until such time that the licensee is in full compliance with O. Reg. 79/10, s. 17 (1) (g), formalized measures shall be taken by the licensee, to ensure vigilance of resident safety by staff, through regular enhanced monitoring intervals of those identified areas wings, where, when a call is activated and there is no audible sound, especially on evenings and night shifts.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg 79/10, r. 17 (1) (g) in that every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
* 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.

It was determined that the Home uses a resident-staff communication system, commonly referred to as a call bell system, in which a person (resident, staff or visitor) in any resident's room can send a signal for assistance by engaging a button on a cord attached to a call bell station; in the resident's washroom or the tub/shower room, a person (resident, staff or visitor) can pull a call bell pull cord that engages the pull station of a call bell to send a signal. Once engaged, the signal for the call bell system activates a light outside the door of the resident's room, and an audible alarm, along with a location display on a panel at the central nursing station, sounds. The Home does not use a pager system linked into the call bell system. The layout of the Home's wings does not favor good viewing of residents' lights outside the rooms or down a corridor.

The Home's call bell system, which uses sound to alert staff, only emanates from the central nursing station on the first floor (or the second floor, if engaged from a second floor room). However, when the doors to the first floor's special care dementia unit are closed and secured, there is no audible sound within the C-100 wing's mid to end of hallway to alert staff of an active call emanating from residents' rooms, toilets and tub/shower rooms. In addition, there is no audible sound within the D-100 wing's hallway of the first floor and, there is no audible sound within the C-200 and D-200 wings' hallways of the second floor, specifically from mid to end of hallways in those identified wings.

During this inspection, Inspector #546 verified the call bell system in the secured access dementia wing on the first floor. When activating a call, by pressing the button at the console in the residents' rooms, specifically for rooms 101, 102, 105, 107, 110, 111, 112 and 114, or by pulling the cord, pressing the call-bell in the toilets and tub/shower room, there was no audible sound within the hallway of the C-100 wing of the first floor. When interviewed by the Inspector, the PSW staff on the secured unit reported relying on the lights outside the rooms in the corridor.

Equally during this inspection, Inspector #126 reported that when activating a call from residents' rooms, specifically rooms 126, 127, 128, 130 and 132, there was no audible sound within the hallway of the D-100 wing of the first floor. In addition, Inspector #550 also reported that when activating a call from residents' rooms, specifically rooms 210, 227, 228, 229 and 231, there was no audible sound within the hallway of the C-200 and D-200 wings of the second floor.

It must be noted that a resident-staff communication and response system is required in those identified areas for use by residents, as per O. Reg. 79/10, s.17 (1) (e). The fact that only residents may be in those certain areas, it does not negate the need for audible sound availability for all staff, especially when the staff ratio is reduced on evenings and nights. The lack of audible sound availability from the call bell system, identified in those areas, accessed by residents, staff or visitors, is a potential risk to the health, safety and comfort and well-being of residents who may not be able to call or have calls placed for assistance by staff or visitors.

This area of non-compliance was issued as a voluntary plan of correction during the May 2014 RQI. The Administrator informed the Inspector that although the communication and response system was reviewed by a technician, it was not corrected due to costs. As of the exit date of this inspection, there was no audible sound within the hallway of the secured unit and from the rooms noted above. (546)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

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.

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 20th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Wendt

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