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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 20, 2014	2014_346133_0004	S-000511-13 AND TWO OTHER LOGS	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): August 6th - 8th, 2014

The following logs were inspected: S-000511-13, S-000512-13, S-000513-13

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, registered and non registered nursing staff, and residents.

During the course of the inspection, the inspector(s) reviewed newly revised policies and procedures related to the resident-staff communication and response system, including "staff personal response badge", "resident personal response badge" and "personal response system - overview". The inspector reviewed a selection of completed 24 hour badge audit forms as provided by the Administrator. The inspector reviewed battery change forms from the care units, as well as system "badges with low batteries" reports as provided by the Administrator. The inspector reviewed the weekly remote pull station audits, as provided by the Environmental Services Manager. In the company of the Administrator, the inspector tested remote pull stations in resident bathrooms throughout the home. In the company of various home staff, the inspector tested resident Personal Alert Badges.

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 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 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).

Findings/Faits saillants :

1. The home is equipped with a wireless resident-staff communication and response

system (the system). The following is a basic overview of the system and how it is used.

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, located throughout the home, interface with these PABs. Every nursing staff member is required to wear their PAB at all times while on shift. The 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. The exception is that PSWs who are on bath duty do not carry pagers. Above all resident bedrooms and common area doorways (i.e: activity rooms, dining rooms, lounges…etc), there are dome lights. A white light is expected to illuminate when a call is made with a PAB or from a remote station in that bedroom or common area. This serves to inform all staff, particularly those not carrying a pager, that a resident is in need of assistance. 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. When the staff PAB is detected, this cancels the call for assistance and signals to others that a nursing staff person is present.

2. The licensee has failed to comply with 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 (but is not limited to) all of the components discussed above, is in good state of repair. During the follow up inspection, the following evidence was found that demonstrates that certain system components, specifically resident Personal Alert Badges, do not always function consistently or reliably. This presents a pattern of ongoing potential risk to the residents of the home.

3. Resident #009 PAB was not able to make a call for assistance when the resident activated it, twice, on August 6th, 2014. The resident's PAB was not in a good state of repair at the time of testing, due to a lack of consistent operational reliability. Full details are provided below:

On August 6th, 2014, at 1:53pm, the Assistant Director of Care (ADOC) and the Inspector proceeded to bedroom #W15, to verify the functioning of resident #009's

PAB. The resident was on their bed at the time, and the PAB was on the bed side table. The inspector introduced themselves to the resident, handed the PAB to them, and asked them if they could show the inspector how they make a call for assistance. The inspector knelt down so as to closely observe the resident's actions. The inspector noted that the badge was dirty with dried white residue. The inspector clearly saw the resident push the red button, and heard the "click" as the button was pressed. The ADOC confirmed hearing the click as well. This action did not result in a call for assistance. The white dome light did not illuminate above the doorway. The PSW in the area, staff member #S104 confirmed there was no call to either pager she was carrying. The system computer console at the Kirkland nurse station did not reflect that a call was made. Following the resident's attempt at making a call, the inspector attempted it. A call was successfully made by the inspector, using resident #009's PAB.

The inspector spoke with the PSW, staff member #S105, who had signed off on testing this resident's PAB during the day shift. The PSW stated that the badge had been fine that morning, that it had been tested before breakfast. When asked for further details however, the PSW elaborated that the badge had not worked when the resident had tried it, but it had worked when the PSW tried it herself.

It is noted that there is no PAB cleaning program in place.

4. Resident #010's PAB was not able to make a call for assistance when the Inspector and when the resident initially activated it on August 6th, 2014. The resident's PAB was not in a good state of repair at the time of testing, due to a lack of consistent operational reliability. Full details are provided below:

On August 7th, 2014, at 9:42am, the Inspector tested resident #010's PAB. The resident was sitting in their wheelchair at the time, in front of the Teck unit nurse station. There were no staff in the immediate area. The Inspector knelt down and introduced themselves to the resident, and asked if they were agreeable to testing their PAB. While the resident nodded, they made no move to press the white button on their PAB. The inspector enquired if they could press it, and the resident was agreeable. The inspector pressed the white button and no call was made. The PSWs who had the pagers for this unit, staff # S106 and #S107 confirmed there was no call from resident #010 to their pagers. The Inspector then asked the resident if they could try to make a call with their PAB. Staff #S106 and #S107 were asked to stay out of the area, to ensure that the signals from their staff PABs did not interfere with the testing.

The resident pressed the white button in, and again no call was made. The ESM arrived on site during this second attempt. The Administrator was informed and immediately came to the unit. The Administrator tested resident #010's PAB with the badge tester. Following this manipulation, the ESM pressed the white button and the PAB made a call, that went to the primary pager and was reflected on the system console. The Administrator informed that the badge tester had not indicated there was a problem with the PAB.

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 in June 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 in October 2012, the two compliance orders (COs) were complied, but problems remained with the system. Ongoing issues were addressed in CO #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 in September 2013, CO #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. As a result of follow up inspection #2013_304133_0033, conducted in November 2013, CO#001 was issued pursuant to O. Reg. 79/10, s. 17 (1) (c), CO#002 was issued pursuant to O. Reg. 79/10, s.17 (1) (f), and CO#003 was issued pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order pursuant to this section.

This ongoing non-compliance related to the resident-staff communication and response system presents a pattern of potential risk to the residents of the home, with regards to it's functional unreliability. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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). The following is a basic overview of the system and how it is used.

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, located throughout the home, interface with these PABs. Every nursing staff member is required to wear their PAB at all times while on shift. The 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. The exception is that PSWs who are on bath duty do not carry pagers. Above all resident bedrooms and common area doorways (i.e: activity rooms, dining rooms, lounges…etc), there are dome lights. A white light is expected to illuminate when a call is made with a PAB or from a remote station in that bedroom or common area. This serves to inform all staff, particularly those not carrying a pager, that a resident is in need of assistance. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, when the ceiling sensor in that area detects their PAB. When the staff PAB is

detected, this cancels the call for assistance and signals to others that a nursing staff person is present.

1.1 - The licensee has failed to comply with O. Reg. 79/10, s. 17 (1) c. in that the licensee has failed to ensure that the home is equipped with 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 pattern of potential risk to the residents of the home.

1.2 - On August 6th, 2014, the initial calls made from resident #001's PAB, from within bedroom #W11, had to be cancelled from within bedroom #W9, and from the WH hallway near #W7. These were not the points of activation. Full details are provided below:

On August 6th, 2014, the inspector made a call for assistance from resident #001's PAB, from within their bedroom in the Wright Hargraeves unit (WH unit), #W11. The inspector pressed the button, and then went out into the hallway, noting that the white dome light was not illuminated above the resident's doorway. The inspector did notice that the white dome light was illuminated above bedroom #W9. It had not been illuminated when the Inspector first went into #W11. The Inspector went to find nursing staff, to verify if a call had been made to their pagers. The PSW who was carrying both pagers at the time, staff # S100, informed the inspector that there was a call reflecting that resident #001 required assistance. Staff # S100 was on the neighbouring unit at the time. The Inspector asked what location was displayed on the pager, and staff # S100 indicated they had not noticed. Staff #S100 further explained that they had just been on the WH unit, and they knew resident #001 was resting, so they assumed they were still in their bedroom. Staff #S100 returned to the WH unit with the inspector. It was confirmed that resident # 002, who resides in #W9, had not made a call for assistance. Staff #S100 cancelled the call, from within #W9. Staff #S100 then went into #W11, and asked resident #001 to make a call from their PAB. It was observed that the white dome light illuminated above #W9, and the pager indicated that resident #001 required assistance in room #W9. Staff #S100 cancelled the call, made by resident #001 in room #W11, from within room #W9. It is noted that another PSW, Staff # S101, was also in the area and involved in discussions about this issue with the Inspector and staff #S100. Staff #S100 then took the PAB out into the hallway, stood under the ceiling sensor close to bedroom #W7, and made a call with the PAB. On this attempt, the pager accurately reflected that resident #001

required assistance in the corridor, near #W7. Approximately 15 minutes later, in the company of staff #S100, two calls were made from resident #001's PAB, from within bedroom #W11. On both occasions, the call reflected on staff # S100's pager as originating from the hallway, near #W7. Staff #S100 then took resident #001's PAB out into the corridor, near #W7, waved it under the system sensor, and returned it to the resident in #W11. Following this intervention, the resident's PAB accurately reflected its location when a call was made.

Extensive retesting of resident 001's PAB, on August 7th, 2014, in a variety of locations, in the company of the Environmental Services Manager (ESM) and the Administrator, could not reproduce the issue.

1.3 - On August 8th, 2014, the initial calls from resident #003 and #004's PAB, made from within the 2nd floor auditorium, had to be cancelled within the 2nd floor lobby. This was not the point of activation of these calls. Full details are provided below:

On August 8th, 2014, in the company of the ESM, shortly after 10am, resident # 003's PAB was tested. The resident was in the 2nd floor auditorium, to the immediate left of the entrance, in an area where residents do puzzles. There were no staff in the area. The resident was not within visual range from the lobby. The resident's PAB was affixed to their upper shirt area, but was flipped over. The PAB was flipped right side up, and engaged by the inspector. A call was made, but the residents location was reflected on the staff pagers (PSWs, staff # S102 and #S103) as originating from "lobby 1001". The white dome light did not illuminate over the doorway into the auditorium. The inspector asked staff #S103, who had the primary pager, where "lobby 1001" was. Staff #S103 indicated they did not know for sure, but guessed it was the lobby outside of the auditorium, and said that they assumed the resident was doing puzzles in the auditorium, as that is customary for resident #003 at this time. As this event was being discussed, it was noted that staff # S103's pager then reflected that resident #003 now needed assistance in "elevator lobby 2000". It is most likely that this occurred as the ceiling sensor in the lobby was picking up on resident #003's PAB signal, from within the auditorium. Another resident, #004, came into the auditorium at the same time, and settled in the general area where the Inspector, ESM, and resident # 003 were. A call was made from resident #004's PAB, and the location of the call was reflected as "elevator lobby 2000". The ESM took both resident's PABs into the center of the auditorium, closer to a system ceiling sensor, and made calls from the PABs. On this attempt, the location of the call was accurately reflected as coming from the auditorium and the white dome light illuminated above

the auditorium door.

The ESM noted that a system ceiling sensor was needed in the immediate entrance area of the auditorium in order to accurately capture the location of residents who may be calling for assistance in this area.

1.4 - It is noted that in the past, the Licensee was ordered to implement a comprehensive resident badge testing program. As a result of inspection #2013_304133_0033, conducted in November 2013, the Licensee was served CO #001 and CO #002, on December 13, 2013. In CO #002, it was specifically ordered that "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 was cross reference to and within CO#001, which was to ensure that the system allows calls to be cancelled only at the point of activation. Such a testing program was not implemented. This testing program was in part intended to assist the Licensee in determining if there were any areas in the home in which additional system ceiling sensors were needed. At the time of the above referenced inspection, it was determined that another system ceiling sensor was needed in the back corner of the 1st floor Parklane Dining Room/Lounge area. During that inspection, a call was made by a resident in that area, as they were doing puzzles, and the call was reflected as coming from the care unit hallway. Similarly, a call was made by a resident at a nearby table, and the call was reflected as coming from that resident's bedroom.

It is noted that nursing staff do test resident PABs, on the day and evening shift, in the location in which they find the resident at the time of testing. In this way, some resident PAB's have been tested in some common areas.

1.5 - The inspector reviewed documented resident badge testing and noted examples of calls from the system not accurately reflecting the location of the resident. If a call is reflected as originating from a certain area, the call can only be cancelled in that area. The inspector found no evidence of intervention or follow up to these reported issues. The following are some examples:

Kirkland Unit:

July 15th, resident #005 – call made from bedroom W7 – staff noted "rang in hallway, received page and light in her room"

July 19th, resident #006 – call made from bedroom W10 – staff note "received page at KNS but rang in her room". K.N.S = kirkland nurse station.

Teck Unit – May 23, resident #007 – call made from lobby, - staff note "pager says he's in M7"

Teck Unit- June 29, resident #008 – call made from dining room – staff note : "rang in dining room, under his sweater, showed in M9" (his bedroom).

These calls had to have been cancelled from the area reflected on the staff pager, which was not the point of activation.

1.6 - It is noted that following discussion with the Administrator about the above documented issues, a memo was issued to all PSW's and registered staff on the matter. The memo directed "when you are testing the badges and the message on your pager is a different location than where the resident is, you need to make a notation of why that has happened. It could be that the badge is flipped over, under a sweater, etc. You need to correct the badge position and retest. If the location does not change, then you must report this to your team leader".

1.7 - 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 in June 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 in October 2012, the two compliance orders (COs) were complied, but problems remained with the system. Ongoing issues were addressed in CO #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 in September 2013, CO #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. As a result of follow up inspection

#2013_304133_0033, conducted in November 2013, CO#001 was issued pursuant to O. Reg. 79/10, s. 17 (1) (c), CO#002 was issued pursuant to O. Reg. 79/10, s.17 (1) (f), and CO#003 was issued pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), which was linked to the existing previous order pursuant to this section.

This ongoing non compliance related to the resident-staff communication and response system presents a pattern of potential risk to the residents of the home. [s. 17. (1) (c)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 17 (1) (f). in that the licensee has failed to ensure that the home is equipped with resident-staff communication and response system that clearly indicates 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 potential risk to the residents of the home.

2.1 - The system did not clearly indicate, when activated by resident #001's PAB in bedroom #W11 on August 6th, 2014, where the signal was coming from. Full details are provided below:

On August 6th, 2014, the inspector made a call for assistance from resident #001's PAB, from within their bedroom in the Wright Hargraeves unit (WH unit), #W11. The inspector pressed the button, and then went out into the hallway, noting that the white dome light was not illuminated above the resident's doorway. The inspector did notice that the white dome light was illuminated above bedroom #W9. It had not been illuminated when the Inspector first went into #W11. The Inspector went to find nursing staff, to verify if a call had been made to their pagers. The PSW who was carrying both pagers at the time, staff # S100, informed the inspector that there was a call reflecting that resident #001 required assistance. Staff # S100 was on the neighbouring unit at the time. The Inspector asked what location was displayed on the pager, and staff # S100 indicated they had not noticed. Staff #S100 further explained that they had just been on the WH unit, and they knew resident #001 was resting, so they assumed they were still in their bedroom. Staff #S100 returned to the WH unit with the inspector. It was confirmed that resident # 002, who resides in #W9, had not made a call for assistance. Staff #S100 cancelled the call, from within #W9. Staff #S100 then went into #W11, and asked resident #001 to make a call from their PAB. It was observed that the white dome light illuminated above #W9, and the pager indicated that resident #001 required assistance in room #W9. Staff #S100 cancelled

the call, made by resident #001 in room #W11, from within room #W9. It is noted that another PSW, Staff # S101, was also in the area and involved in discussions about this issue with the Inspector and staff #S100. Staff #S100 then took the PAB out into the hallway, stood under the ceiling sensor close to bedroom #W7, and made a call with the PAB. On this attempt, the pager accurately reflected that resident #001 required assistance in the corridor, near #W7. Approximately 15 minutes later, in the company of staff #S100, two calls were made from resident #001's PAB, from within bedroom #W11. On both occasions, the call reflected on staff # S100's pager as originating from the hallway, near #W7. Staff #S100 then took resident #001's PAB out into the corridor, near #W7, waved it under the system sensor, and returned it to the resident in #W11. Following this intervention, the resident's PAB accurately reflected its location when a call was made.

Extensive retesting of resident 001's PAB, on August 7th, 2014, in a variety of locations, in the company of the Environmental Services Manager (ESM) and the Administrator, could not reproduce the issue.

2.2 - On August 8th, 2014, the system did not clearly indicate, when activated by resident #002 and #003's PAB, from within the 2nd floor auditorium, where the signal was coming from.

On August 8th, 2014, in the company of the ESM, shortly after 10am, resident # 003's PAB was tested. The resident was in the 2nd floor auditorium, to the immediate left of the entrance, in an area where residents do puzzles. There were no staff in the area. The resident was not within visual range from the lobby. The resident's PAB was affixed to their upper shirt area, but was flipped over. The PAB was flipped right side up, and engaged by the inspector. A call was made, but the residents location was reflected on the staff pagers (PSWs, staff # S102 and #S103) as originating from "lobby 1001". The white dome light did not illuminate over the doorway into the auditorium. The inspector asked staff #S103, who had the primary pager, where "lobby 1001" was. Staff #S103 indicated they did not know for sure, but guessed it was the lobby outside of the auditorium, and said that they assumed the resident was doing puzzles in the auditorium, as that is customary for resident #003 at this time. As this event was being discussed, it was noted that staff # S103's pager then reflected that resident #003 now needed assistance in "elevator lobby 2000". It is most likely that this occurred as the ceiling sensor in the lobby was picking up on resident #003's PAB signal, from within the auditorium. Another resident, #004, came into the auditorium at the same time, and settled in the general area where the Inspector,

ESM, and resident # 003 were. A call was made from resident #004's PAB, and the location of the call was reflected as "elevator lobby 2000". The ESM took both resident's PABs into the center of the auditorium, closer to a system ceiling sensor, and made calls from the PABs. On this attempt, the location of the call was accurately reflected as coming from the auditorium and the white dome light illuminated above the auditorium door.

The ESM noted that a system ceiling sensor was needed in the immediate entrance area of the auditorium in order to accurately capture the location of residents who may be calling for assistance in this area.

2.3 - It is noted that in the past, the Licensee was ordered to implement a comprehensive resident badge testing program. As a result of inspection #2013_304133_0033, conducted in November 2013, the Licensee was served CO #001 and CO #002, on December 13, 2013. In CO #002, it was specifically ordered that "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 was cross reference to and within CO#001, which was to ensure that the system allows calls to be cancelled only at the point of activation. Such a testing program was not implemented. This testing program was in part intended to assist the Licensee in determining if there were any areas in the home in which additional system ceiling sensors were needed. At the time of the above referenced inspection, it was determined that another system ceiling sensor was needed in the back corner of the 1st floor Parklane Dining Room/Lounge area. During that inspection, a call was made by a resident in that area, as they were doing puzzles, and the call was reflected as coming from the care unit hallway. Similarly, a call was made by a resident at a nearby table, and the call was reflected as coming from that resident's bedroom.

It is noted that nursing staff do test resident PABs, on the day and evening shift, in the location in which they find the resident at the time of testing. In this way, some resident PAB's have been tested in some common areas.

2.4 - The inspector reviewed documented resident badge testing and noted examples of calls from the system not accurately reflecting the location of the resident. If a call is reflected as originating from a certain area, the call can only be cancelled in that

area. The inspector found no evidence of intervention or follow up to these reported issues. The following are some examples:

Kirkland Unit:

July 15th, resident #005 – call made from bedroom W7 – staff noted "rang in hallway, received page and light in her room"

July 19th, resident #006 – call made from bedroom W10 – staff note "received page at KNS but rang in her room". K.N.S = kirkland nurse station.

Teck Unit – May 23, resident #007 – call made from lobby, - staff note "pager says he's in M7"

Teck Unit- June 29, resident #008 – call made from dining room – staff note : "rang in dining room, under his sweater, showed in M9" (his bedroom).

The system, when activated by the above noted resident PAB's, in the above noted locations, did not clearly indicate where the signal is coming from.

2.5 - 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 in June 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 in October 2012, the two compliance orders (COs) were complied, but problems remained with the system. Ongoing issues were addressed in CO #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 in September 2013, CO #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. As a result of follow up inspection #2013_304133_0033, conducted in November 2013, CO#001 was issued pursuant to O. Reg. 79/10, s. 17 (1) (c), CO#002 was issued pursuant to O. Reg. 79/10, s.17 (1) (f), and CO#003 was issued pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order pursuant to this section.

This ongoing non compliance related to the resident-staff communication and response system presents a pattern of potential risk to the residents of the home. [s. 17. (1) (f)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 21st day of August, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2014_346133_0004
Log No. / Registre no:	S-000511-13 AND TWO OTHER LOGS
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 20, 2014
Licensee / Titulaire de permis :	CORPORATION OF THE TOWN OF KIRKLAND LAKE 3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4
LTC Home / Foyer de SLD :	TECK PIONEER RESIDENCE 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

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2013_304133_0033, CO #003;

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 prepare, submit and implement a plan for ensuring that all components of the resident staff communication and response system is in a good state of repair, with a focus on ensuring that all resident's Personal Alert Badges (PABs) operate consistently and reliably. This plan is to include, but not be limited to the following:

a) When staff undertake the process of testing resident PABs, on the day and evening shift, it is the resident who is to demonstrate that a call can be made from the PAB. If the resident's first attempt to make a call for assistance is not successfull, then the process is to continue until such time that the resident can successfully make a call from their PAB, or from a new PAB, if needed.

b) If the resident's first attempt to make a call for assistance is not successfull, this is to be documented, on the 24 hour badge audit form. This may be suggestive of a trend, either that the PAB is not functioning reliably, or the resident is having difficulty properly manipulating the PAB without guidance from staff, necessitating consideration of other means of making calls, for that resident.

c) During the day and evening shift PAB testing, staff are to make note if the PAB is dirty, and registered staff who review the documented testing program

are to make arrangements for the PAB to be cleaned and returned to the resident as soon as is possible. Alternate means of making a call are to be provided to the resident while the PAB is being cleaned. The cleaning process may require disassembling the PAB.

d) Related to any problems documented on the 24 hour badge audit forms, and on the remote pull station audit forms, the licensee is to ensure that associated corrective action is also documented on the forms. As well, the Administrator or designate must always be looking for trends, within all related system documentation, that may be indicative of system issues. For example if a resident's PAB battery needs to be changed much more frequently than the norm, if a certain remote pull station fails more frequently than others, or if a certain dome light fails more frequently than others.

This plan may be submitted in writing to Long Term Care Home Inspector Jessica Lapensée at 347 Preston Street, 4th floor, Ottawa, Ontario, K1S 3J4. Alternately, the plan may be faxed to the inspector's attention at (613) 569-9670.This plan must be received by Thursday, August 28th, 2014. This plan must be fully implemented by September 22, 2014.

Grounds / Motifs :

1. The home is equipped with a wireless resident-staff communication and response system (the system). The following is a basic overview of the system and how it is used.

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, located throughout the home, interface with these PABs. Every nursing staff member is required to wear their PAB at all times while on shift. The 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. The exception is that PSWs who are on bath duty do not carry pagers. Above all resident bedrooms and common area doorways (i.e: activity rooms, dining rooms, lounges…etc), there are dome lights. A white light is expected to illuminate when a call is made with a PAB or from a remote

station in that bedroom or common area. This serves to inform all staff, particularly those not carrying a pager, that a resident is in need of assistance. 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. When the staff PAB is detected, this cancels the call for assistance and signals to others that a nursing staff person is present.

2. The licensee has failed to comply with 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 (but is not limited to) all of the components discussed above, is in good state of repair. During the follow up inspection, the following evidence was found that demonstrates that certain system components, specifically resident Personal Alert Badges, do not always function consistently or reliably. This presents a pattern of ongoing potential risk to the residents of the home.

3. Resident #009 PAB was not able to make a call for assistance when the resident activated it, twice, on August 6th, 2014. The resident's PAB was not in a good state of repair at the time of testing, due to a lack of consistent operational reliability. Full details are provided below:

On August 6th, 2014, at 1:53pm, the Assistant Director of Care (ADOC) and the Inspector proceeded to bedroom #W15, to verify the functioning of resident #009's PAB. The resident was on their bed at the time, and the PAB was on the bed side table. The inspector introduced themselves to the resident, handed the PAB to them, and asked them if they could show the inspector how they make a call for assistance. The inspector knelt down so as to closely observe the resident's actions. The inspector noted that the badge was dirty with dried white residue. The inspector clearly saw the resident push the red button, and heard the "click" as the button was pressed. The ADOC confirmed hearing the click as well. This action did not result in a call for assistance. The white dome light did not illuminate above the doorway. The PSW in the area, staff member #S104 confirmed there was no call to either pager she was carrying. The system computer console at the Kirkland nurse station did not reflect that a call was made. Following the resident's attempt at making a call, the inspector attempted it. A call was successfully made by the inspector, using resident #009's PAB.

The inspector spoke with the PSW, staff member #S105, who had signed off on testing this resident's PAB during the day shift. The PSW stated that the badge

had been fine that morning, that it had been tested before breakfast. When asked for further details however, the PSW elaborated that the badge had not worked when the resident had tried it, but it had worked when the PSW tried it herself.

It is noted that there is no PAB cleaning program in place.

4. Resident #010's PAB was not able to make a call for assistance when the Inspector and when the resident initially activated it on August 6th, 2014. The resident's PAB was not in a good state of repair at the time of testing, due to a lack of consistent operational reliability. Full details are provided below:

On August 7th, 2014, at 9:42am, the Inspector tested resident #010's PAB. The resident was sitting in their wheelchair at the time, in front of the Teck unit nurse station. There were no staff in the immediate area. The Inspector knelt down and introduced themselves to the resident, and asked if they were agreeable to testing their PAB. While the resident nodded, they made no move to press the white button on their PAB. The inspector enquired if they could press it, and the resident was agreeable. The inspector pressed the white button and no call was made. The PSWs who had the pagers for this unit, staff # S106 and #S107 confirmed there was no call from resident #010 to their pagers. The Inspector then asked the resident if they could try to make a call with their PAB. Staff #S106 and #S107 were asked to stay out of the area, to ensure that the signals from their staff PABs did not interfere with the testing. The resident pressed the white button in, and again no call was made. The ESM arrived on site during this second attempt. The Administrator was informed and immediately came to the unit. The Administrator tested resident #010's PAB with the badge tester. Following this manipulation, the ESM pressed the white button and the PAB made a call, that went to the primary pager and was reflected on the system console. The Administrator informed that the badge tester had not indicated there was a problem with the PAB.

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 in June 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 in October 2012, the two

compliance orders (COs) were complied, but problems remained with the system. Ongoing issues were addressed in CO #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 in September 2013, CO #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. As a result of follow up inspection #2013_304133_0033, conducted in November 2013, CO#001 was issued pursuant to O. Reg. 79/10, s. 17 (1) (c), CO#002 was issued pursuant to O. Reg. 79/10, s.17 (1) (f), and CO#003 was issued pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order pursuant to this section.

This ongoing non-compliance related to the resident-staff communication and response system presents a pattern of potential risk to the residents of the home, with regards to it's functional unreliability. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 22, 2014

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2013_304133_0033, CO #001;

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.

A call is cancelled only in the location where the system reflects the call signal has originated from. In this way, if the system does not accurately reflect a resident's Personal Alert Badge (PAB) location, the call can only be cancelled in that location. CO #002 and CO #003 therefore address intertwined issues.

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 install system sensors in any/all locations where they may be lacking, such as within the entrance area of the Auditorium. This is in part to be based on a one time, full home resident PAB testing program, where selected PAB's will be tested in representative areas in all common spaces. Specifically,

testing is not only to be done in the immediate area of an existing sensor. For example, in the Auditorium, PAB signals were accurately detected when the PAB was closer to the center of the room, but not near the entrance area, in which there is a defined activity zone. In the Chapel, a PAB signal was accurately detected when tested in the center of the back pew, within obvious range to the existing sensor. The testing program is to verify that a PAB signal can be accurately detected if the PAB is located more towards the corners of the room, in the pews, for example.

b) All staff, in all departments, are to undertake the responsibility for ensuring that resident PAB's are properly affixed to resident's clothing, so that the PAB is not covered up and is facing upwards, at all times. It is acknowledged that some residents will not be agreable to this. Such resident's preference to wear their PAB under their clothing, despite education as to the potential signal detection complications this may cause, must be documented in the plan of care.

c) As per the licensee's policy "Resident Personal Response Badge", revised date March 2014, nursing staff are to ensure that when a resident is in bed, that their PAB is secured in a place where the resident can easily access the badge and where the system can sense it. If a resident wears their PAB to bed, and it is obscured by clothing and linens, their PAB can still be used to make a call, but their location will not be detected, and the white dome light above their bedroom door will not illuminate.

d) When nursing staff have to cancel a call from a PAB in a location other than the location from which the call was actually made, this is to be documented on the "24 hour badge audit form", or another such form, and corrective action and follow up is also to be documented. This documentation is to be reviewed by the Administrator, or designate, for trends, and specific interventions are to be put in place as needed.

Grounds / Motifs :

1. The home is equipped with a wireless resident-staff communication and response system (the system). The following is a basic overview of the system and how it is used.

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, located throughout the home, interface with

these PABs. Every nursing staff member is required to wear their PAB at all times while on shift. The 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. The exception is that PSWs who are on bath duty do not carry pagers. Above all resident bedrooms and common area doorways (i.e: activity rooms, dining rooms, lounges…etc), there are dome lights. A white light is expected to illuminate when a call is made with a PAB or from a remote station in that bedroom or common area. This serves to inform all staff, particularly those not carrying a pager, that a resident is in need of assistance. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, when the ceiling sensor in that area detects their PAB. When the staff PAB is detected, this cancels the call for assistance and signals to others that a nursing staff person is present.

1.1 - The licensee has failed to comply with O. Reg. 79/10, s. 17 (1) c. in that the licensee has failed to ensure that the home is equipped with 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 pattern of potential risk to the residents of the home.

1.2 - On August 6th, 2014, the initial calls made from resident #001's PAB, from within bedroom #W11, had to be cancelled from within bedroom #W9, and from the WH hallway near #W7. These were not the points of activation. Full details are provided below:

On August 6th, 2014, the inspector made a call for assistance from resident #001's PAB, from within their bedroom in the Wright Hargraeves unit (WH unit), #W11. The inspector pressed the button, and then went out into the hallway, noting that the white dome light was not illuminated above the resident's doorway. The inspector did notice that the white dome light was illuminated above bedroom #W9. It had not been illuminated when the Inspector first went into #W11. The Inspector went to find nursing staff, to verify if a call had been made to their pagers. The PSW who was carrying both pagers at the time, staff # S100, informed the inspector that there was a call reflecting that resident #001

required assistance. Staff # S100 was on the neighbouring unit at the time. The Inspector asked what location was displayed on the pager, and staff # S100 indicated they had not noticed. Staff #S100 further explained that they had just been on the WH unit, and they knew resident #001 was resting, so they assumed they were still in their bedroom. Staff #S100 returned to the WH unit with the inspector. It was confirmed that resident # 002, who resides in #W9, had not made a call for assistance. Staff #S100 cancelled the call, from within #W9. Staff #S100 then went into #W11, and asked resident #001 to make a call from their PAB. It was observed that the white dome light illuminated above #W9, and the pager indicated that resident #001 required assistance in room #W9. Staff #S100 cancelled the call, made by resident #001 in room #W11, from within room #W9. It is noted that another PSW, Staff # S101, was also in the area and involved in discussions about this issue with the Inspector and staff #S100. Staff #S100 then took the PAB out into the hallway, stood under the ceiling sensor close to bedroom #W7, and made a call with the PAB. On this attempt, the pager accurately reflected that resident #001 required assistance in the corridor, near #W7. Approximately 15 minutes later, in the company of staff #S100, two calls were made from resident #001's PAB, from within bedroom #W11. On both occasions, the call reflected on staff # S100's pager as originating from the hallway, near #W7. Staff #S100 then took resident #001's PAB out into the corridor, near #W7, waved it under the system sensor, and returned it to the resident in #W11. Following this intervention, the resident's PAB accurately reflected its location when a call was made.

Extensive retesting of resident 001's PAB, on August 7th, 2014, in a variety of locations, in the company of the Environmental Services Manager (ESM) and the Administrator, could not reproduce the issue.

1.3 - On August 8th, 2014, the initial calls from resident #003 and #004's PAB, made from within the 2nd floor auditorium, had to be cancelled within the 2nd floor lobby. This was not the point of activation of these calls. Full details are provided below:

On August 8th, 2014, in the company of the ESM, shortly after 10am, resident # 003's PAB was tested. The resident was in the 2nd floor auditorium, to the immediate left of the entrance, in an area where residents do puzzles. There were no staff in the area. The resident was not within visual range from the lobby. The resident's PAB was affixed to their upper shirt area, but was flipped over. The PAB was flipped right side up, and engaged by the inspector. A call

was made, but the residents location was reflected on the staff pagers (PSWs, staff # S102 and #S103) as originating from "lobby 1001". The white dome light did not illuminate over the doorway into the auditorium. The inspector asked staff #S103, who had the primary pager, where "lobby 1001" was. Staff #S103 indicated they did not know for sure, but guessed it was the lobby outside of the auditorium, and said that they assumed the resident was doing puzzles in the auditorium, as that is customary for resident #003 at this time. As this event was being discussed, it was noted that staff # S103's pager then reflected that resident #003 now needed assistance in "elevator lobby 2000". It is most likely that this occurred as the ceiling sensor in the lobby was picking up on resident #003's PAB signal, from within the auditorium. Another resident, #004, came into the auditorium at the same time, and settled in the general area where the Inspector, ESM, and resident # 003 were. A call was made from resident #004's PAB, and the location of the call was reflected as "elevator lobby 2000". The ESM took both resident's PABs into the center of the auditorium, closer to a system ceiling sensor, and made calls from the PABs. On this attempt, the location of the call was accurately reflected as coming from the auditorium and the white dome light illuminated above the auditorium door.

The ESM noted that a system ceiling sensor was needed in the immediate entrance area of the auditorium in order to accurately capture the location of residents who may be calling for assistance in this area.

1.4 - It is noted that in the past, the Licensee was ordered to implement a comprehensive resident badge testing program. As a result of inspection #2013_304133_0033, conducted in November 2013, the Licensee was served CO #001 and CO #002, on December 13, 2013. In CO #002, it was specifically ordered that "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 was cross reference to and within CO#001, which was to ensure that the system allows calls to be cancelled only at the point of activation. Such a testing program was not implemented. This testing program was in part intended to assist the Licensee in determining if there were any areas in the home in which additional system ceiling sensors were needed. At the time of the above referenced inspection, it was determined that another system ceiling sensor was needed in the back corner of the 1st floor Parklane Dining Room/Lounge area. During that

inspection, a call was made by a resident in that area, as they were doing puzzles, and the call was reflected as coming from the care unit hallway. Similarly, a call was made by a resident at a nearby table, and the call was reflected as coming from that resident's bedroom.

It is noted that nursing staff do test resident PABs, on the day and evening shift, in the location in which they find the resident at the time of testing. In this way, some resident PAB's have been tested in some common areas.

1.5 - The inspector reviewed documented resident badge testing and noted examples of calls from the system not accurately reflecting the location of the resident. If a call is reflected as originating from a certain area, the call can only be cancelled in that area. The inspector found no evidence of intervention or follow up to these reported issues. The following are some examples:

Kirkland Unit:

July 15th, resident #005 – call made from bedroom W7 – staff noted "rang in hallway, received page and light in her room"

July 19th, resident #006 – call made from bedroom W10 – staff note "received page at KNS but rang in her room". K.N.S = kirkland nurse station.

Teck Unit – May 23, resident #007 – call made from lobby, - staff note "pager says he's in M7"

Teck Unit- June 29, resident #008 – call made from dining room – staff note : "rang in dining room, under his sweater, showed in M9" (his bedroom).

These calls had to have been cancelled from the area reflected on the staff pager, which was not the point of activation.

1.6 - It is noted that following discussion with the Administrator about the above documented issues, a memo was issued to all PSW's and registered staff on the matter. The memo directed "when you are testing the badges and the message on your pager is a different location than where the resident is, you need to make a notation of why that has happened. It could be that the badge is flipped over, under a sweater, etc. You need to correct the badge position and retest. If the location does not change, then you must report this to your team leader".

1.7 - 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 in June 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 in October 2012, the two compliance orders (COs) were complied, but problems remained with the system. Ongoing issues were addressed in CO #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 in September 2013, CO #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. As a result of follow up inspection #2013_304133_0033, conducted in November 2013, CO#001 was issued pursuant to O. Reg. 79/10, s. 17 (1) (c), CO#002 was issued pursuant to O. Reg. 79/10, s.17 (1) (f), and CO#003 was issued pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), which was linked to the existing previous order pursuant to this section.

This ongoing non compliance related to the resident-staff communication and response system presents a pattern of potential 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 : Oct 20, 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_304133_0033, CO #002;

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 (the system) that clearly indicates when activated where the signal is coming from.

If the system indicates that a call signal from a resident's Personal Alert Badge (PAB) is coming from a location other than where the resident is in fact located, staff must go to the incorrect location in order to cancel the call. In this way, CO #002 and CO #003 address intertwined issues.

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 within the entrance area of the Auditorium. This is in part to be based on a one time, full home resident PAB testing program, where selected PAB`s will be tested in representative areas in all common spaces. Specifically,

testing is not only to be done in the immediate area of an existing sensor. For example, in the Auditorium, PAB signals were accurately detected when the PAB was closer to the center of the room, but not near the entrance area, in which there is a defined activity zone. In the Chapel, a PAB signal was accurately detected when tested in the center of the back pew, within obvious range to the existing sensor. The testing program is to verify that a PAB signal can be accurately detected if the PAB is located more towards the corners of the room, in the pews, for example.

b) All staff, in all departments, are to undertake the responsibility for ensuring that resident PAB's are properly affixed to resident`s clothing, so that the PAB is not covered up and is facing upwards, at all times. It is acknowledged that some residents will not be agreable to this. Such resident's preference to wear their PAB under their clothing, despite education as to the potential signal detection complications this may cause, must be documented in the plan of care.

c) As per the licensee`s policy "Resident Personal Response Badge", revised date March 2014, nursing staff are to ensure that when a resident is in bed, that their PAB is secured in a place where the resident can easily access the badge and where the system can sense it. If a resident wears their PAB to bed, and it is obscured by clothing and linens, their PAB can still be used to make a call, but their location will not be detected, and the white dome light above their bedroom door will not illuminate.

d) When nursing staff have to cancel a call from a PAB in a location other than the location from which the call was actually made, this is to be documented on the "24 hour badge audit form", or another such form, and corrective action and follow up is also to be documented. This documentation is to be reviewed by the Administrator, or designate, for trends, and specific interventions are to be put in place as needed.

Grounds / Motifs :

1. The home is equipped with a wireless resident-staff communication and response system (the system). The following is a basic overview of 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, located throughout the home, interface with these PABs. Every nursing staff member is required to wear their PAB at all

times while on shift. The 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. The exception is that PSWs who are on bath duty do not carry pagers. Above all resident bedrooms and common area doorways (i.e: activity rooms, dining rooms, lounges…etc), there are dome lights. A white light is expected to illuminate when a call is made with a PAB or from a remote station in that bedroom or common area. This serves to inform all staff, particularly those not carrying a pager, that a resident is in need of assistance. 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. When the staff PAB is detected, this cancels the call for assistance and signals to others that a nursing staff person is present.

1.1 - The licensee has failed to comply with O. Reg. 79/10, s. 17 (1) (f). in that the licensee has failed to ensure that the home is equipped with resident-staff communication and response system that clearly indicates 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 potential risk to the residents of the home.

1.2 - The system did not clearly indicate, when activated by resident #001's PAB in bedroom #W11 on August 6th, 2014, where the signal was coming from. Full details are provided below:

On August 6th, 2014, the inspector made a call for assistance from resident #001's PAB, from within their bedroom in the Wright Hargraeves unit (WH unit), #W11. The inspector pressed the button, and then went out into the hallway, noting that the white dome light was not illuminated above the resident's doorway. The inspector did notice that the white dome light was illuminated above bedroom #W9. It had not been illuminated when the Inspector first went into #W11. The Inspector went to find nursing staff, to verify if a call had been made to their pagers. The PSW who was carrying both pagers at the time, staff # S100, informed the inspector that there was a call reflecting that resident #001 required assistance. Staff # S100 was on the neighbouring unit at the time. The Inspector asked what location was displayed on the pager, and staff # S100

indicated they had not noticed. Staff #S100 further explained that they had just been on the WH unit, they knew resident #001 was resting, so they assumed they were still in their bedroom. Staff #S100 returned to the WH unit with the inspector. It was confirmed that resident # 002, who resides in #W9, had not made a call for assistance. Staff #S100 cancelled the call, from within #W9. Staff #S100 then went into #W11, and asked resident #001 to make a call from their PAB. It was observed that the white dome light illuminated above #W9, and the pager indicated that resident #001 required assistance in room #W9. Staff #S100 cancelled the call, made by resident #001 in room #W11, from within room #W9. It is noted that another PSW, Staff # S101, was also in the area and involved in discussions about this issue with the Inspector and staff #S100. Staff #S100 then took the PAB out into the hallway, stood under the ceiling sensor close to bedroom #W7, and made a call with the PAB. On this attempt, the pager accurately reflected that resident #001 required assistance in the corridor, near #W7. Approximately 15 minutes later, in the company of staff #S100, two calls were made from resident #001's PAB, from within bedroom #W11. On both occasions, the call reflected on staff # S100's pager as originating from the hallway, near #W7. Staff #S100 then took resident #001's PAB out into the corridor, near #W7, waved it under the system sensor, and returned it to the resident in #W11. Following this intervention, the resident's PAB accurately reflected its location when a call was made.

Extensive retesting of resident 001's PAB, on August 7th, 2014, in a variety of locations, in the company of the Environmental Services Manager (ESM) and the Administrator, could not reproduce the issue.

1.3 - On August 8th, 2014, the system did not clearly indicate, when activated by resident #002 and #003's PAB, from within the 2nd floor auditorium, where the signal was coming from.

On August 8th, 2014, in the company of the ESM, shortly after 10am, resident # 003's PAB was tested. The resident was in the 2nd floor auditorium, to the immediate left of the entrance, in an area where residents do puzzles. There were no staff in the area. The resident was not within visual range from the lobby. The resident's PAB was affixed to their upper shirt area, but was flipped over. The PAB was flipped right side up, and engaged by the inspector. A call was made, but the residents location was reflected on the staff pagers (PSWs, staff # S102 and #S103) as originating from "lobby 1001". The white dome light did not illuminate over the doorway into the auditorium. The inspector asked staff

#S103, who had the primary pager, where "lobby 1001" was. Staff #S103 indicated they did not know for sure, but guessed it was the lobby outside of the auditorium, and said that they assumed the resident was doing puzzles in the auditorium, as that is customary for resident #003 at this time. As this event was being discussed, it was noted that staff # S103's pager then reflected that resident #003 now needed assistance in "elevator lobby 2000". It is most likely that this occurred as the ceiling sensor in the lobby was picking up on resident #003's PAB signal, from within the auditorium. Another resident, #004, came into the auditorium at the same time, and settled in the general area where the Inspector, ESM, and resident # 003 were. A call was made from resident #004's PAB, and the location of the call was reflected as "elevator lobby 2000". The ESM took both resident's PABs into the center of the auditorium, closer to a system ceiling sensor, and made calls from the PABs. On this attempt, the location of the call was accurately reflected as coming from the auditorium and the white dome light illuminated above the auditorium door.

The ESM noted that a system ceiling sensor was needed in the immediate entrance area of the auditorium in order to accurately capture the location of residents who may be calling for assistance in this area.

1.4 - It is noted that in the past, the Licensee was ordered to implement a comprehensive resident badge testing program. As a result of inspection #2013_304133_0033, conducted in November 2013, the Licensee was served CO #001 and CO #002, on December 13, 2013. In CO #002, it was specifically ordered that "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 was cross reference to and within CO#001, which was to ensure that the system allows calls to be cancelled only at the point of activation. Such a testing program was not implemented. This testing program was in part intended to assist the Licensee in determining if there were any areas in the home in which which additional system ceiling sensors were needed. At the time of the above referenced inspection, it was determined that another system ceiling sensor was needed in the back corner of the 1st floor Parklane Dining Room/Lounge area. During that inspection, a call made by a resident in that area, as they were doing puzzles, and the call was reflected as coming from the care unit hallway. Similarly, a call was made by a resident at a nearby table, and the call was

reflected as coming from that resident's bedroom.

It is noted that nursing staff do test resident PABs, on the day and evening shift, in the location in which they find the resident at the time of testing. In this way, some resident PAB's have been tested in some common areas.

1.5 - The inspector reviewed documented resident badge testing and noted examples of calls from the system not accurately reflecting the location of the resident. If a call is reflected as originating from a certain area, the call can only be cancelled in that area. The inspector found no evidence of intervention or follow up to these reported issues. The following are some examples:

Kirkland Unit:

July 15th, resident #005 – call made from bedroom W7 – staff noted "rang in hallway, received page and light in her room"

July 19th, resident #006 – call made from bedroom W10 – staff note "received page at KNS but rang in her room". K.N.S = kirkland nurse station.

Teck Unit – May 23, resident #007 – call made from lobby, - staff note "pager says he's in M7"

Teck Unit- June 29, resident #008 – call made from dining room – staff note : "rang in dining room, under his sweater, showed in M9" (his bedroom).

The system, when activated by the above noted resident PAB's, in the above noted locations, did not clearly indicate where the signal is coming from.

1.6 - 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 in June 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 in October 2012, the two compliance orders (COs) were complied, but problems remained with the system. Ongoing issues were addressed in CO #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 in September 2013, CO #001 was issued, pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order. As a result of follow up inspection #2013_304133_0033, conducted in November 2013, CO#001 was issued pursuant to O. Reg. 79/10, s. 17 (1) (c), CO#002 was issued pursuant to O. Reg. 79/10, s.17 (1) (f), and CO#003 was issued pursuant to LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c), and was linked to the existing previous order pursuant to this section.

This ongoing non compliance related to the resident-staff communication and response system presents a pattern of potential 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 : Oct 20, 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.

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 August, 2014

Signature of Inspector /
Signature de l'inspecteur :

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

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