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 6, 2015	2014_332575_0021	S-000480-14	Resident Quality Inspection

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

LINDSAY DYRDA (575), GILLIAN CHAMBERLIN (593), MONIKA GRAY (594)

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): November 17-21 and 24-28, 2014

In addition, the following log(s) were inspected:
Follow-Up log(s): S-000373-14, S-000374-14, S-000375-14;
Critical Incident log(s): S-000425-14

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Assistant Director of Care (ADOC), Maintenance Coordinator, Food Services Coordinator (FSC), Dietary Staff, Activity Coordinator, Clinical Coordinator, Business Office Coordinator, Nurse Practitioner, Restorative Care Aide (RCA), Registered Nursing Staff, Personal Support Workers (PSW), Family Members, and Resident's.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **6 VPC(s)**
- **2 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 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 licensee has failed to comply with O. Reg. 79/10, s. 15 (2) in that the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. This is specifically related to the home's resident-staff communication and response system.

The home is equipped with a wireless resident-staff communication and response system- Versus Personal Response System. According to the home's policy, each resident is assigned a Personal Response Badge (PAB) upon admission to the home which is configured in the system and kept current at all times to identify the resident assigned to wear/or use the PAB. The residents' assigned PSW shall ensure that the PAB is worn by the resident at all times and/or secured in a place easily accessible by the resident in his/her room when the resident is not in bed. When a resident is in bed, badges shall be secured in a place where the resident can easily access the badge. In addition, every nursing staff position on each resident home area shall be assigned a PAB. The PAB shall be worn by the designated staff position at all times during a shift. Nursing staff shall verify during their shift that his/her assigned PAB is functioning properly using the badge audit form. Each PSW shall verify during their shift that his/her assigned residents have a working PAB. The "Badge Audit" is completed on day shift and evening shift, activating each resident PAB (resident activates if able), ensuring the dome light illuminates and a page is received.

On each resident unit, all PSW's (with exception to bath PSW's) are to carry a pager which receives calls made from the PAB's. There are also remote pull stations on the walls in resident washrooms and common areas, and calls made from these stations are also received by the pagers carried by the PSW's. The system is not audible however there is a dome light outside each resident room and common area which illuminates indicating where the call was made from. This also allows staff members who are not carrying a pager to identify any residents in need of assistance.

There are numerous sensors installed throughout the home which interact with the Versus Personal Response System. There are sensors located in resident's rooms, resident washrooms, tub rooms and common areas within the home. The sensors should allow the location of the resident to be communicated through the pager to advise the PSW exactly where the resident requiring assistance is. The Versus system allows for a response time report that can be generated for a chosen area and time period within the home. This report shows all calls made during that period, including the time the call was

made, the location of where the call was made and the time a staff member responded to the call.

Multiple non-compliances have been previously identified related to this communication and response system:

• During an inspection completed October 2012 under inspection 2012_054133_0041, the two previous compliance orders (CO) were complied however due to additional system problems an additional CO was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair.

• During an inspection completed September 2013 under inspection 2013_204133_0024 a CO was issued pursuant to the LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued October 2012.

• During an inspection completed December 2013 under inspection 2013_304133_0033 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and one compliance order issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued September 2013.

• During an inspection completed August 20, 2014 under inspection 2014_346133_0004 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and were linked to previous existing compliance orders issued December 2013; one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued December 2013.

1. Resident #3264 was unable to place a call when the PAB was first activated November 26, 2014. Furthermore, when the call was then successfully placed, there was a delay in assistance as the call was not received by the pager until 13 minutes after the call was placed.

On November 26, 2014, inspector #593 entered resident #3264's bedroom and observed that their PAB was not visible. It was found that the resident was wearing their PAB under their sweater. The resident was asked to place a call by pressing the button on their PAB. The dome light in the hallway did not illuminate, which indicated that a call had not been made. The resident was asked to press the button on their PAB for a second time and this time the dome light did illuminate in the hallway, which indicated that a call had been placed. The call was placed at 09:25, however, at 09:39 there was still no response by staff to the call. PSW #406 was located and they confirmed that their pager had received the call, but the time of the call displayed on the pager was 09:38, 13 minutes after the call was actually placed by the resident. The inspector confirmed that PSW #406 had the primary pager for this area.

2. Resident #3264 placed a call November 26, 2014, however when the call was successfully placed the call was not received by the pager until 5 minutes after the call was placed.

On November 26, 2014, inspector #593 requested that resident #1495 place a call by pressing the button on their PAB. The dome light in the hallway illuminated, which indicated that a call was made. A student Nurse responded to the call as they had seen the dome light illuminated in the hallway, however they did not have a pager. PSW #402 then responded to the call and they had a pager. PSW #402 confirmed to the inspector that they had the primary pager for that area. The inspector observed that the pager accurately reflected the location of the call, however the time of the call on the pager was not accurate. The pager indicated that the call was placed at 09:59, when in fact the call was placed at 09:54, five minutes earlier. The inspector reviewed the documented 24 hour PAB checks for November 26, 2014 and noted that the checks for the day shift had been completed by PSW #402 and that it was documented for resident #1495 that "time delay shown when page received".

3. Inspector #593 placed a call from resident #4355's washroom, however there was a delay in assistance as the call was not received by the pager until 5 minutes after the call was placed.

On November 26, 2014, inspector #593 placed a call from resident #4355's washroom at 11:11. The dome light in the hallway was illuminated and flashing, which indicated that a call had been made from the washroom. PSW #403 responded to the call at 11:17 and the location of the call on the pager was correct, however the time on the pager was not correct. The pager indicated that the call was placed at 11:16, five minutes after the call

was actually placed. PSW #403 confirmed to the inspector that they had the primary pager for the area, and told the inspector that there is sometimes a delay in the calls being received by the pager.

During an interview with inspector #593 on November 27, 2014, the Administrator was made aware of the issue regarding the delay from the time a call is made until the time the call is received by a pager. The Administrator advised that they were unaware of this issue. The inspector reviewed the home's documented 24 hour PAB checks and noted that on September 05, 2014 in one of the units, it was indicated that there was a nine minute delay from the time a call was placed until the time it was received by the pager. During a previous interview with the Administrator, they advised that these reports were reviewed monthly for any issues with the Versus resident communication system. According to the home's policy: Personal Response System- Overview, the ADOC or Administrator will review the audit forms weekly coordinating with the Maintenance Coordinator to ensure malfunctioning equipment that was documented by the PSW's has been reported and repaired.

Multiple examples of PAB call delays to staff pagers were found during the inspection. This presents a pattern of potential risk to residents in the home should they require urgent assistance from a staff member.

4. Resident #2712 was unable to place a call when their PAB was first activated on November 25, 2014. Furthermore, the resident advised the inspector of earlier problems they encountered when trying to place a call for assistance.

On November 25, 2014 inspector #593 requested resident #2712 to place a call by pressing the button on their PAB. The resident pressed the button however the dome light did not illuminate in the hallway, which indicated that a call had not been made. The resident was asked to press the PAB button once more and the dome light illuminated in the hallway, which indicated that a call had been made and a PSW responded to the call. During this time, resident #2712 advised the inspector that earlier that afternoon they had attempted to place a call at 15:30, however there had been no response from staff after they had pressed their PAB button. The resident then asked their roommate, (resident #003) to place a call (which they did successfully) and a PSW responded to the call. The response time report indicating calls made by residents showed no call placed by resident #2712 around 15:30. During an interview with inspector #593 on November 26, 2014, resident #003 confirmed resident #2712's earlier statement and explanation related to the malfunctioning PAB and confirmed their role in assisting resident #2712 in

calling for staff with their own PAB.

5. Resident #1658 was unable to place a call when the PAB was activated twice November 26, 2014. Furthermore, the resident was unable to locate the PAB on their person and when a call was placed successfully on the third try, the location of the resident on the pager was incorrect.

On November 26, 2014 inspector #593 observed resident #1658 at the puzzle table in the auditorium and noted that their PAB was not visible. Resident #1658 was asked to place a call by pressing the button on their PAB, however the resident could not locate their PAB in order to attempt to make a call. A visitor, who was also seated at the puzzle table, located the resident's PAB which had flipped up and over the resident's shoulder. The PAB had been clipped high up on the resident's shoulder. The visitor handed the PAB to the resident as the resident was unable to locate it on their own. The resident pressed the button on the PAB twice and the dome light in the hallway did not illuminate, which indicated that a call had not been made. The resident pressed the PAB button a third time and this time the dome light outside of the auditorium illuminated, which indicated that a call had been made. The resident successfully made a call on their third attempt, however as discussed further in CO #002, the location on the pager was incorrect. According to the home's policy: Personal Response System- Overview, each resident's assigned care giver shall be responsible to ensure that the personal response badge is attached to the residents clothing and/or is secured close enough for the resident to reach it in the event of an emergency.

6. Resident #1658's call was not received by the pager on two occasions. However, on both occasions the dome light illuminated which indicated that a call had been successfully made.

On November 27, 2014 the home's Administrator and inspector #593 requested that resident #0425 place a call by pressing the button on their PAB. Resident #0425 was observed to press the PAB button and the dome light outside of their bedroom illuminated, which indicated that a call had been placed. Both pagers for that location were in the possession of the Administrator. Neither pager received a call at this time from resident #0425. The resident was asked to place a second call. The resident pressed the PAB button and the dome light outside of their bedroom illuminated, which indicated that a call had been made. Again, the call was not received by the pagers. The Administrator speculated that the call may not be coming through to the pagers as the resident was covering the PAB sensor with their hand when they were pressing the

button. Resident #0425 was asked for a third time to press the button on their PAB and to ensure that their hand or fingers were not covering the sensor. After the third attempt, the call was received by the pager which displayed the correct time and location. At this time, inspector #593 observed a PSW move the resident's PAB as the resident was having difficulty reaching the PAB where it was currently located, clipped high up on the residents shoulder. As per the home's policy, the badge shall be worn by the resident at all times and/or secured in a place easily accessible by the resident in his/her room when the resident is not in bed.

7. Resident #002 placed a call which was received by the pager however the dome light failed to illuminate which indicated that a call had been placed.

On November 27, 2014 inspector #593 observed the Administrator request that resident #002 make a call by pressing the button on their PAB. The resident was observed to press the button, however the dome light in the hallway did not illuminate. However, the call was received by the primary pager which was being held by the Administrator. The Administrator speculated that the dome light did not illuminate as the resident was wearing their PAB under their sweater. It is to be noted that only minutes earlier, it was observed that resident #0425 covered their PAB sensor with their hand when placing a call and that their bedroom dome light illuminated, however it failed to be received twice by the pagers. As bath PSW's do not carry pagers, they rely on the dome lights to indicate any residents requiring assistance and if the dome light does not illuminate when a call is placed, the PSW's without pagers are unable to identify residents requiring assistance.

8. Resident #4497 placed a call in the dining room which was not received by the pager and the dome light outside of the dining room failed to illuminate.

On November 27, 2014 inspector #593 observed the Administrator request resident #4497, who was in the dining room, place a call by pressing the button on their PAB. The resident was observed to place the call however the dome light outside the dining room did not illuminate nor did the pager receive the call. The Administrator then asked the resident to try again, and as a result of the second attempt, the dome light outside of the dining room illuminated and the call was received by the pager which indicated the correct location. The Administrator noted that the PAB was initially under the resident's apron and speculated that this may be the reason why the call did not go through on the first attempt.

This non-compliance related to the resident-staff communication and response system presents a pattern of on-going potential risk to the residents in the home due to the unreliability of placing calls and calls being successfully received. As such, the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [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 licensee has failed to comply with O. Reg. 79/10, s. 17 (1) (a) in that the licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be seen, accessed and used by residents, staff and visitors at all times.

1. The resident was asked to place a call however they could not locate their PAB as it

was clipped high on their shoulder and had flipped over. Once the resident had their PAB, they made two failed attempts at placing a call before a call went through on the third attempt.

On November 26, 2014 inspector #593 observed resident #1658 at the puzzle table in the auditorium and noted that their PAB was not visible. Resident #1658 was asked to place a call by pressing the button on their PAB, however the resident could not locate their PAB in order to attempt to make a call. A visitor, who was also seated at the puzzle table, located the resident's PAB, which had flipped up and over the resident's shoulder. The PAB had been clipped high up on the resident's shoulder. The visitor handed the PAB to the resident as the resident was unable to locate it on their own. According to the home's policy: Personal Response System- Overview, each resident's assigned care giver shall be responsible to ensure that the personal response badge is attached to the resident's clothing and/or is secured close enough for the resident to reach it in the event of an emergency.

2. The resident was asked to place a call and after three failed attempts a call had still not been successfully made. The inspector then took the PAB and placed a call, which was successfully received by the pager.

On November 26, 2014 inspector #593 entered resident #6355's room and requested the resident to place a call by pressing the button on their PAB, which they did. The dome light in the hallway did not illuminate, which indicated that a call had not been placed. Unrelated to this call, the RPN then entered the resident's room to administer medications. After the RPN left, the resident was asked to once again press the button on their PAB to place a call. The resident pressed the button two more times and the dome light did not illuminate in the hallway, which indicated again that a call had not been made. Inspector #593 then pressed the button on the PAB to place the call and this time the dome light in the hallway did illuminate, which indicated that a call had been made.

3. The resident was asked to place a call and after two failed attempts at placing a call, the resident was able to successfully place a call on the third attempt. It was observed by the inspector that the resident was having difficulty reaching the PAB where it was currently located clipped high up on their shoulder.

On November 27, 2014 the home's Administrator and inspector #593 requested that resident #0425 place a call by pressing the button on their PAB. Resident #0425 was

observed to press the PAB button and the dome light outside of their bedroom illuminated, which indicated that a call had been placed. Both pagers for that location were in the possession of the Administrator. Neither pager received a call at this time from resident #0425. The resident was asked to place a second call. The resident pressed the PAB button and the dome light outside of their bedroom illuminated, which indicated that a call had been made. Again, the call was not received by the pagers. The Administrator speculated that the call may not be coming through to the pagers as the resident was covering the PAB sensor with their hand when they were pressing the button. Resident #0425 was asked for a third time to press the button on their PAB and to ensure that their hand or fingers were not covering the sensor. After this third attempt, the call was received by the pager which displayed the correct time and location. At this time, inspector #593 observed a PSW move the resident's PAB as the resident was having difficulty reaching the PAB where it was currently located clipped high up on the residents shoulder. As per the home's policy, the badge shall be worn by the resident at all times and/or secured in a place easily accessible by the resident in his/her room when the resident is not in bed.

This non-compliance related to the resident-staff communication and response system presents a pattern of on-going potential risk to residents in the home due to the unreliability of the system and calls being placed. As such, the licensee has failed to ensure that there is a resident-staff communication and response system that can be easily seen, accessed and used by residents at all times. [s. 17. (1) (a)]

2. 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 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 residents' PAB location, the call can only be cancelled in that location. CO #002 therefore addresses intertwined issues under O.Reg, s.17 (1) (c) and s.17 (1) (f).

Multiple non-compliances have been previously identified related to this communication and response system:

• During an inspection completed June 2012 under inspection 2012_054133_0028 two CO's were issued, pursuant to O.Reg 79/10, s. 17. (1) (b) the licensee failed to ensure that the home is equipped with a resident-staff communication and response system that

is on at all times.

• During an inspection completed December 2013 under inspection 2013_304133_0033 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued September 2013.

• During an inspection completed August 20, 2014 under inspection 2014_346133_0004 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and were linked to previous existing CO's issued December 2013; one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued December 2013.

1. Resident #0425 was observed to place a call from their room, however the location on the pager indicated that the resident was in the washroom. As a result, staff had to cancel the call from the resident's washroom which was the incorrect location as to where the resident was calling from.

On November 25, 2014 inspector #593 requested resident #0425 to make a call by pressing the button on their PAB. The call was successfully made and PSW #405 responded to the call however the location on the PSW's pager indicated that the resident was in the washroom when in fact the resident was in their bedroom sitting by the window at the time of placing the call.

2. A call was placed by inspector #593 after resident #6355 failed to place a call on two occasions. The placed call did not reflect a location for the resident on the pager. As a result, staff were not required to cancel the call from residents current location.

On November 26, 2014 inspector #593 entered resident #6355's room and requested the resident to place a call by pressing the button on their PAB, which they did. The dome light in the hallway did not illuminate, which indicated that a call had not been placed. Unrelated to this call, the RPN then entered the resident's room to administer medications. After the RPN left, the resident was asked to once again press the button

on their PAB to place a call. The resident pressed the button two more times and the dome light did not illuminate in the hallway, which indicated again that a call had not been made. Inspector #593 then pressed the button on the PAB to place the call and this time the dome light in the hallway did illuminate, which indicated that a call had been made. The bath PSW responded as they saw the dome light illuminated in the hallway, however they did not have a pager and therefore went to locate a PSW with a pager. PSW# 402 then attended the call as a result of the bath PSW. The inspector observed PSW #402's pager and noted that a call from resident #6355's PAB was registered, but the location of the PAB at the time of the call was not reflected. When asked by the inspector how the resident would be located, PSW #402 responded that they knew where the resident was at that time as a result of the bath PSW advising them, however usually the call details on the pager showed the location of the resident.

3. After two failed attempts, a call was placed by resident #1658. The call was received by the pager however the location displayed on the pager was incorrect and did not reflect where the resident was when they placed the call.

On November 26, 2014 inspector #593 observed resident #1658 at the puzzle table in the auditorium. Resident #1658 was asked to place a call by pressing the button on their PAB. After two failed attempts, the resident placed a call and the light outside of the auditorium illuminated, which indicated that a call had been made. PSW #402 responded to the call. The inspector noted that the call time on the pager was correct, however the location indicated that the resident was in the elevator lobby which is outside of the auditorium. PSW #402 speculated that this was because the resident was closer to the sensor in the elevator lobby. Inspector #593 observed that the resident was seated directly under a sensor in the auditorium which was in fact closer than the sensor in the elevator lobby. A CO was previously issued under inspection 2014_346133_0004 completed August 20, 2014 related to calls placed by residents in the auditorium. Calls from the auditorium showed on the pager as being placed in the elevator lobby, therefore the calls had to be cancelled in the elevator lobby as the location on the pager was incorrect.

During an interview with inspector #593 on November 27, 2014 the Administrator speculated that the elevator lobby sensor may have picked up resident #1658's PAB signal on their way through to the auditorium. Inspector #593 pointed out that the PAB activity report for this period accurately reflected that the resident was in the auditorium when the call was placed. The Administrator was unable to explain this.

4. Residents #002 and #6355 were observed to be wearing their PAB's under their sweaters. According to the home's policy, the impact of not having the PAB visible is that the location reflected on the pager will be of the last location that the PAB was picked up by the sensor, which may not accurately reflect the location of the resident.

On November 26, 2014 inspector #593 entered resident #002's room and observed that their PAB was not visible. The resident showed that their PAB was under their sweater. Shortly after, inspector #593 entered resident #6355's room and observed that the PAB was not visible as the resident was also wearing it under their sweater.

During an interview with inspector #593 on November 26, 2014, the Administrator advised that some residents prefer to wear their PAB's under their sweaters and this is documented in the resident's plan of care. A review of resident #3264, #6355 and #002's plans of care found no mention of the resident's preference for wearing their PAB underneath their sweater. In all three care plans, the only detail regarding the PAB was to "ensure badge is attached to clothing at all times". According to the home's policy: Personal Response System- Overview, the impact of not having the PAB visible is that the location reflected on the pager will be of the last location that the PAB was picked up by the sensor which may not accurately reflect the location of the resident. The policy also stated that it is important to ensure that badges are not covered up and remain proper side up at all times.

This non-compliance related to the resident-staff communication and response system presents a pattern of on-going potential risk to residents in the home due to the unreliability of the system. For the call to be cancelled, staff members must enter the area displayed on the pager with their PAB. Therefore, if the location displayed on the pager is incorrect, the staff member must go to that displayed location to cancel the call instead of the location where the resident requesting assistance actually is. As such, the licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that allows calls to be canceled only at the point of activation. [s. 17. (1) (c)]

3. 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 a resident-staff communication and response system that clearly indicates where the signal is coming from.

Multiple non-compliances have been previously identified related to this communication and response system:

• During an inspection completed June 2012 under inspection 2012_054133_0028 two CO's were issued, pursuant to O.Reg 79/10, s. 17. (1) (b) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times.

• During an inspection completed December 2013 under inspection 2013_304133_0033 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued September 2013.

• During an inspection completed August 20, 2014 under inspection 2014_346133_0004 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and were linked to previous existing CO's issued December 2013; one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued December 2013.

1. Resident #0425 was observed to place a call from their room however the location on the pager indicated that the resident was in the washroom.

On November 25, 2014 inspector #593 requested resident #0425 to make a call by pressing the button on their PAB. The call was successfully made and PSW #405 responded to the call, however the location on the PSW's pager indicated that the resident was in the washroom when in fact the resident was in their bedroom sitting by the window at the time of placing the call.

2. A call was placed by inspector #593 after resident #6355 failed to place a call on two occasions. The placed call did not reflect a location for the resident on the pager.

On November 26, 2014 inspector #593 entered resident #6355's room and requested the resident to place a call by pressing the button on their PAB, which they did. The dome light in the hallway did not illuminate, which indicated that a call had not been placed. Unrelated to this call, the RPN then entered the residents' room to administer

medications. After the RPN left, the resident was asked to once again press the button on their PAB to place a call. The resident pressed the button two more times and the dome light did not illuminate in the hallway, which indicated again that a call had not been made. Inspector #593 then pressed the button on the PAB to place the call and this time the dome light in the hallway did illuminate, which indicated that a call had been made. The bath PSW responded as they saw the dome light illuminated in the hallway, however they did not have a pager and therefore went to locate a PSW with a pager. PSW #402 then attended the call as a result of the bath PSW. The inspector observed PSW #402's pager and noted that a call from resident #6355's PAB was registered, but the location of the PAB at the time of the call was not reflected. When asked by the inspector how the resident would be located, PSW #402 responded that they knew where the resident was at that time as a result of the bath PSW advising them, however usually the call details on the pager showed the location of the resident.

3. A call was placed by resident #1658 after two failed attempts. The call was received by the pager however the location displayed on the pager was incorrect and did not reflect where the resident was when they placed the call.

On November 26, 2014 inspector #593 observed resident #1658 at the puzzle table in the auditorium. Resident #1658 was asked to place a call by pressing the button on their PAB. The resident placed a call and the light outside of the auditorium illuminated, which indicated that a call had been made. PSW #402 responded to the call. The inspector noted that the call time on the pager was correct, however the location indicated that the resident was in the elevator lobby which is outside of the auditorium. PSW #402 speculated that this was because the resident was closer to the sensor in the elevator lobby. Inspector #593 observed that the resident was seated directly under a sensor in the auditorium which was in fact closer than the sensor in the elevator lobby. A CO was previously issued under inspection 2014_346133_0004 completed August 20, 2014 related to calls placed by residents in the auditorium. Calls from the auditorium showed on the pager as being placed in the elevator lobby therefore the pager did not reflect the correct location of the resident.

During an interview with inspector #593 on November 27, 2014 the Administrator speculated that the elevator lobby sensor may have picked up resident #1658's PAB signal on their way through to the auditorium. Inspector #593 pointed out that the PAB activity report for this period accurately reflected that the resident was in the auditorium when the call was placed. The Administrator was unable to explain this.

4. Residents #002 and #6355 were observed to be wearing their PAB's under their sweaters. According to the home's policy the impact of not having the PAB visible is that the location reflected on the pager will be of the last location that the PAB was picked up by the sensor, which may not accurately reflect the location of the resident.

On November 26, 2014 inspector #593 entered resident #002's room and observed that their PAB was not visible. The resident showed that their PAB was under their sweater. Shortly after, inspector #593 entered resident #6355's room and observed that the PAB was not visible as the resident was also wearing it under their sweater.

During an interview with inspector #593 November 26, 2014, the Administrator advised that some residents prefer to wear their PAB's under their sweaters and this is documented in the resident's plan of care. A review of resident #3264, #6355 and #002's plan of care found no mention of the resident's preference for wearing their PAB underneath their sweater. In all three care plans, the only detail regarding the PAB was to "ensure badge is attached to clothing at all times". According to the home's policy Personal Response System- Overview, the impact of not having the PAB visible is that the location reflected on the pager will be of the last location that the PAB was picked up by the sensor which may not accurately reflect the location of the resident. The policy also stated that it is important to ensure that badges are not covered up and remain proper side up at all times.

This non-compliance related to the resident-staff communication and response system presents a pattern of on-going potential risk to residents in the home due to the unreliability of the system reflecting the location of the resident when a call has been placed. As such, the licensee has failed to ensure that there is a resident-staff communication and response system that clearly indicates when activated where the signal is coming from. [s. 17. (1) (f)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. Inspector #575 reviewed resident #0845's health care record in regards to an infection the resident experienced in 2014. The resident's care plan indicated that the staff are to keep the resident's oxygen saturation levels at a specified level. The care plan also indicated that staff are to monitor the resident's oxygen saturation levels however it did not indicate how often to monitor. On two occasions, the inspector observed the resident in bed with no oxygen applied. The inspector asked staff member #200 how often the staff are to monitor the resident's oxygen saturation levels. The staff member told the

inspector that staff monitor the oxygen levels when the resident is not feeling well. The inspector then interviewed staff member #201 about the resident's care plan. Staff member #201 told the inspector that the resident has not had oxygen applied for approximately 3 months and that the care plan should now indicate that oxygen saturation levels should be monitored 'as needed'. The licensee has failed to ensure that the plan of care for resident #0845 set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. During an interview, resident #0933 told inspector #594 of non-pharmacological pain management interventions that were effective for them. Inspector #594 interviewed staff member #400 who stated a non-pharmacological pain intervention for resident #0933. Staff #300 stated to inspector #594 two non-pharmacological pain interventions that are effective for resident #0933. Inspector #594 reviewed resident #0933's Medication Administration Record (MAR) which stated one non-pharmacological pain intervention. The home's Nursing Pain Management Program Policy reviewed March 2014, stated that Registered Nursing staff are to implement strategies to effectively manage pain including pharmacological and non-pharmacological interventions and document on the resident's care plan. The inspector reviewed the current electronic care plan for resident #0933 and noted that the non-pharmacological pain interventions indicated by the resident and staff were not identified. The licensee has failed to ensure the plan of care is based on an assessment of resident #0933 and the resident's needs and preferences. [s. 6. (2)]

3. During an interview, resident #5354 told inspector #594 of non-pharmacological pain management interventions that were effective for them. Inspector #594 interviewed staff #401 who confirmed two non-pharmacological pain interventions as indicated by the resident. The home's Nursing Pain Management Program Policy reviewed March 2014, stated that Registered Nursing staff are to implement strategies to effectively manage pain including pharmacological and non-pharmacological interventions and document on the residents care plan. The inspector reviewed the current electronic care plan for resident #5354 and noted that the non-pharmacological pain interventions as stated by the resident and staff were not identified. The licensee has failed to ensure the plan of care is based on an assessment of resident #5354 and the resident's needs and preferences. [s. 6. (2)]

4. A review of resident #4355's plan of care by inspector #593 found that the resident is to receive adequate sensory stimulation at least five times per week through various activities including pampering, musical stimulation, and 1:1 visits. The resident is dependent on staff for stimulation and activities. The plan of care further documented

that the resident will have sensory stimulation daily.
During an interview with inspector #593 staff member #403 advised that resident #4355 usually goes back to their room after meals. They further advised that the resident does not receive regular 1:1 activities.
During an interview with inspector #593 staff member #404 advised that resident #4355 spends most of the day in their room and is not involved in any regular activities.
The resident was not observed to be involved in any group or individual activities throughout the duration of the inspection.
A review of the home's Recreation and Leisure Services Policy dated March 2014, found that the program for cognitively impaired residents should provide cognitive and sensory stimulation as well as opportunities for self-expression. The activities should also facilitate social interaction.
A review of resident #4355's activity participation report found the following:
• April 2014- the resident had zero 1:1 visits and two pampering activities.
• May 2014- the resident had zero 1:1 visits and six pampering activities.
• June 2014- the resident had zero 1:1 visits and three pampering activities.
• July 2014- the resident had zero 1:1 visits and five pampering activities.
• August 2014- the resident had zero 1:1 visits, one pampering activity and two wheelchair walks.
• September 2014- the resident had zero 1:1 visits and one pampering activity.
• October 2014- the resident had zero 1:1 visits and three pampering activities.
During an interview with inspector #593 staff member #105 advised that the staff are very limited with what they can do with resident #4355, however they further added that the current activity participation rate for this resident was unacceptable and they would like to see the staff target this resident more with 1:1 activities. They further added that it is in the resident's plan of care to receive at least five 1:1 visits per week but they do not believe that this actually happens.
The licensee has failed to provide regular 1:1 visits with resident #4355 at least five times per week and as such has failed to ensure that the care set out in the plan of care is provided to resident #4355 as specified in the plan. [s. 6. (7)]

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 ensuring that resident #0845's plan of care sets out clear directions to staff and others who provide care to the resident, that resident #5354 and #0933's plan of care is based on an assessment of the residents' and the residents' needs and preferences, and that the care set out in the plan of care is provided to resident #4355 as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Inspector #575 reviewed the home's medication policy: 'Storage' last reviewed March 2014 provided by the home's Administrator. The policy stated the following: 'Prescription creams, ointments, applied by Personal Support Workers shall be kept in the locked clean utility room in the tote carried by the PSW.'
Subject to O.Reg. 79/10, s.129 (1) (a) (i), every licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.
The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act. [s. 8. (1) (a)]

2. Inspector #575 observed medication administration by staff member #200 on November 20, 2014. Staff member #200 was administering a narcotic injection of 1 mg. The medication was provided in an ampule as 2mg/mL. The staff member drew up 0.5mL for the prescribed dose of 1mg. Then, the staff member drew up the remaining amount of medication into a syringe, re-capped the needle and then placed it in the narcotic drawer of the medication cart to be wasted. The staff member told the inspector that normally (if the inspector was not there), they would have drawn up the medication and labelled it for the next scheduled dose for the resident. The inspector asked the staff member what the home's policy was regarding this. The staff member told the inspector that they would have to look up the policy because they did not remember. The staff member told the inspector that they were nervous.
The inspector interviewed staff member #101 about the home's policy regarding narcotics. The staff member was made aware of the inspector's observation. The staff member stated that staff have been re-labelling the narcotics if they are using them again for another dose, however they told the inspector that they reviewed the policy and staff are to waste the medication.
Inspector #575 reviewed the home's medication policy last revised October 2014. The policy indicated the following:
-Pre-pouring of medication is not permitted; and
-Medications must remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident.
The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [s. 8. (1) (b)]

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 ensuring that the home's medication policy 'Storage' is in compliance with and is implemented in accordance with all applicable requirements under the Act and that the medication policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. Inspector #575 reviewed resident #0933's health care record regarding the use of bed rails. The care plan indicated that the resident required the use of bed rails as a PASD for bed mobility. During an interview, staff member #101 told the inspector that the home was not aware of the requirements regarding the use of PASDs. The staff member stated that alternatives to the use of bed rails were verbally discussed with the resident and family regarding the use of a hi-low bed but the resident preferred to use bed rails for safety. Inspector interviewed staff member #201 regarding how the use of bed rails are determined. Staff member #201 stated that the risk of falls assessment is part of determining use of bed rails along with observation of the resident, and the restraint committee discusses the use. The restraint committee minutes, monthly analysis, and annual evaluation binder was reviewed by the inspector. The binder included monthly analysis from 2011, 2012, 2013, and 2014 (to October). The monthly analysis included the resident, type of restraint, reason for device, consent/physician orders, least restrictive, restraint reduction, reasons for removal, audit flowsheet, and emergency applications. Resident #0933 was not identified on any of the analysis sheets, nor was the use of any PASD.
The inspector reviewed the resident's health care record. The inspector was unable to locate any consent signed by the resident or the resident's substitute decision maker (SDM), nor any indication that alternatives to the use of a PASD was considered or if it was the least restrictive. Staff member #101 and staff member #201 confirmed that there was no consent signed by the resident, nor documentation identifying alternatives that were considered to the use of the PASD. The inspector interviewed the resident who told the inspector that they use bed rails when they are in bed. The resident stated that they do not recall if the staff asked for their consent because it was 'awhile ago'. The resident stated that they were originally scared of falling out of bed and that the rails 'somewhat' help with bed mobility. A 'Consent to Physical Restraint/PASD' form was found on the home's policies website, however this form was not included in the resident's health care record.
The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living is included in a resident's plan of care only if:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living;
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living; and

4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 33. (4)]

2. On two occasions resident #0845 was observed in bed with bed rails applied. Inspector #575 reviewed resident #0845's health care record regarding the use of the bed rails. The care plan indicated that the resident required the use of bed rails as a PASD for bed mobility. During an interview, staff member #101 told the inspector that the home was not aware of the requirements regarding the use of PASDs. The staff member stated that alternatives to the use of bed rails were verbally discussed with the resident on admission however the resident preferred to have bed rails for safety. Inspector interviewed staff member #201 regarding how the use of bed rails are determined. Staff member #201 stated that the risk of falls assessment is part of determining use of bed rails along with observation of the resident, and the restraint committee discusses the use.
Staff member #201 stated that resident #0845 insisted on the use of bed rails, and that they think staff have tried a hi-lo bed and to use the bed rails only when needed. The restraint committee minutes, monthly analysis, and annual evaluation binder was reviewed by the inspector. The binder included monthly analysis from 2011, 2012, 2013, and 2014 (to October). The monthly analysis included the resident, type of restraint, reason for device, consent/physician orders, least restrictive, restraint reduction, reasons for removal, audit flowsheet, and emergency applications. Resident #0845 was not identified on any of the analysis sheets, nor was the use of any PASD.
The inspector reviewed the resident's health care record. The inspector was unable to locate any consent signed by the resident or the resident's substitute decision maker (SDM), nor any indication that alternatives to the use of a PASD was considered or if it was the least restrictive. Staff member #101 and staff member #201 confirmed that there was no consent signed by the resident, nor documentation identifying alternatives that were considered to the use of the PASD. The inspector interviewed the resident who told the inspector that both full rails have been applied since their admission and they could not recall if they gave consent. A 'Consent to Physical Restraint/PASD' form was found on the home's policies website, however this form was not included in the resident's health care record.
The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living is included in a resident's plan of care only if:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living;

2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living; and
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 33. (4)]

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 ensuring that where a resident requires the use of a PASD, alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living; the use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living; and that the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #6: 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. During the initial tour of the home, inspector #594 observed the following medicated shampoos and creams in the tub rooms for 2 home areas:
Therapeutic Shampoo, Nizoral Shampoo, Atrac-Tain Cream, Eucerin Cream, and Uremol 20 Cream.
During an interview, staff member #202 told inspector #575 that the medicated creams that the PSWs apply are stored in the clean utility room in a tote and the medicated shampoos are stored in the tub rooms of each home area.
Additionally, inspector #594 observed the following in the resident rooms:
Prescription cream observed beside the television in the resident's room; and
Prescription mouthwash observed on the shelf in a shared bathroom.
Inspector #594 reviewed resident health care records and determined that there was no current order to leave at the bedside for either resident.
Inspectors #575 and #594 observed the clean utility room in the one home area on November 27,2014. The following medicated creams were found: Clotrimazole (DIN #812382); Flamazin (DIN #323098); Heat rub x2, opened and un-labelled.
During stage 1 of the inspection, inspector #575 observed a medication with no label in the shared bathroom in resident #7991 and #2547's room. The medication was observed in the labelled cupboard of resident #7991. Upon review of both residents' health care records, it was determined by the inspector that the medication was actually prescribed for resident #2547, however it was being stored in resident #7991's cupboard. Furthermore, the most recent order did not identify the medication to be stored in the resident's room. During an interview, the staff member #101 told the inspector that

residents are allowed to administer topical medications only if it is ordered by the physician. They stated that medications that are allowed at the resident's bedroom should have a pharmacy label and should be stored in the top drawer of the resident's nightstand. The inspector notified the staff member that a medication was found in a resident #7991's bathroom cupboard for resident #2547. The staff member then told the inspector that the medication ordered for resident #2547 is applied by staff, therefore it should not be stored in the resident's room.
The licensee has failed to ensure that 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 efficiacy, and
(iv) that complies with manuafacturer's instructions for the storage of the drugs. [s. 129. (1) (a)]

2. Inspector #575 observed the medication room on one of the units with staff member #202. The inspector noted that narcotics were double locked in a stationary cupboard in the locked medication room. The inspector then observed the home's emergency drug supply located in a cupboard in the locked medication room. The emergency drug supply included a controlled substance (Lorazepam) which was not double docked in the stationary cupboard within the locked medication room. During an interview, staff member #101 confirmed to the inspector that the Lorazepam was not double locked and they told the inspector that the home has never treated their 'pams' as a controlled substance like narcotics and that it is also not stored in a separate locked area within the locked medication cart. Therefore, the licensee has failed to ensure that 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. [s. 129. (1) (b)]

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 ensuring that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies, that is secure and locked and that 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. Inspector #575 asked staff member #201 for the home's 2013 training records for skin and wound care for direct care staff. The staff member told the inspector that the training

included positioning and catheter care. The records indicated that only 2/14 Registered staff, 30/36 PSWs, and 0/2 Restorative Care Aides (RCA) completed the catheter care training in 2013. The records also indicated that only 9/14 Registered staff, 29/36 PSWs, and 2/2 RCAs completed the training for positioning. Additionally, staff member #202 told the inspector that they have never received skin and wound care training over the last 5 years.
The licensee has failed to ensure that direct care staff are provided annual training in skin and wound care. [s. 221. (1) 2.]

2. Inspector #575 requested the staff training records from 2013 regarding restraint and PASD education. Staff member #201 told the inspector that the 2013 training records could not be found. The inspector requested the staff training records from 2012. Staff member #201 provided the inspector with the number of staff who had completed the 2012 training. In 2012, only 6/16 Registered staff received training on restraints and PASDs and 0/30 PSWs received training on restraints and PASDs. Staff member #201 told the inspector that the actual application of restraints is not included in the training and that the training is primarily on the policy. Staff member #201 told the inspector that currently in 2014 the following staff have completed the training: 4/15 Registered staff, 26/35 PSWS, 1/1 RCA.
The licensee has failed to ensure that training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including application of these physical devices, use of these physical devices, and potential dangers of these physical devices. [s. 221. (1) 5.]

3. Inspector #575 requested the staff training records from 2013 regarding restraint and PASD education. Staff member #201 told the inspector that the 2013 training records could not be found. The inspector requested the staff training records from 2012. Staff member #201 provided the inspector with the number of staff who had completed the 2012 training. In 2012, only 6/16 registered staff received training on restraints and PASDs and 0/30 PSWs received training on restraints and PASDs. Staff member #201 told the inspector that the actual application of restraints is not included in the training and that the training is primarily on the policy. Staff member #201 told the inspector that currently in 2014 the following staff have completed the training: 4/15 registered staff, 26/35 PSWS, 1/1 restorative care aide.
The licensee has failed to ensure that training has been provided for all staff who apply PASD's or who monitor residents with PASD's including application of these PASDs, use of these PASDs, and potential dangers of these PASDs. [s. 221. (1) 6.]

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 ensuring that direct care staff are provided annual training in skin and wound care, restraints (including application, use, and potential dangers of physical devices), and PASD's (including application, use, and potential dangers), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector #593 reviewed the Residents' Council minutes dated September 11, 2014 and noted a documented resident concern that residents' were not allowed to bring coffee into their rooms. The documented response from the home was that "coffee is not allowed in resident rooms due to the fact that it poses a danger because of the temperature and it's in a glass mug".
During an interview with inspector #593 on November 25, 2014, staff member #103 confirmed that residents are not allowed to have hot drinks in their rooms as the drinks may spill and residents could burn themselves. The staff member also confirmed that tea and coffee are only available for residents in the dining room and during activities. They further added that cranberry juice is now back on the menu but only in resident areas that do not have carpet on the floor as the home is concerned that the cranberry juice may spill and stain the carpet.
The inspector reviewed the home's 2014 Fall/Winter cyclical menu and found that coffee and tea are offered at each nourishment, however as confirmed by staff member #103 this is only available to residents if they are in the dining room or in an activity. Therefore, the licensee has failed to ensure that each resident has their choices respected. [s. 3. (1) 19.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. Inspector #575 reviewed resident #0845, #0933, and #5354's health care records for the use of bed rails. According to the care plans, resident #0845 and #0933 use 2 bed

rails as PASD's for bed mobility and resident #5354 uses one bed rail when in bed.
The inspector asked staff member #101 when bed rails are used, if these residents have been assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. The staff member stated that the assessments would be completed by the Registered Nursing staff and/or the RCA. The staff member stated that an assessment is done but was not able to indicate to the inspector what type of assessment and told the inspector that the home does not have a specific bed rail assessment.
The inspector interviewed staff member #104 regarding the assessment for bed rails. The staff member indicated that an assessment would be conducted on admission and include the observation of bed mobility, transferring, lifts, and then the appropriate action to take would be determined and documented in the progress notes. The inspector reviewed the health care records for these residents and did not find any documentation to support the assessment.
The inspector interviewed staff member #201 regarding how the use of bed rails are determined. The staff member stated that risk of falls is part of determining use of bed rails, observation, and the restraint committee discusses.
The restraint committee minutes, monthly analysis, and annual evaluation binder was reviewed by the inspector. The binder included monthly analysis from 2011, 2012, 2013, and 2014 (to October). The monthly analysis included the resident, type of restraint, reason for device, consent/physician orders, least restrictive, restraint reduction, reasons for removal, audit flowsheet, and emergency applications. None of the residents (#0845, #0933, #5354) were discussed at any of the meetings.
The inspector asked the Administrator when bed rails are used, what steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. The inspector was provided a 'Bed Entrapment Audit' for each home area from January 2011. The audit only indicated the room number, whether it met the requirements and if not, what corrective action was completed. The inspector asked the Administrator what requirements the home was assessing for and the Administrator stated that it was 'whatever requirements were set out by the Ministry'. The inspector asked if there was any new bed systems purchased since this audit was completed and the Administrator stated that the home has purchased 8 new beds and indicated that all of the new beds met the entrapment guidelines but was unable to show the inspector anything to support this statement. Staff member #101 told the inspector that the home borrowed a tool from another home to conduct the entrapment audit in January 2011. Further, the audit did not note the bed type or mattress type or each potential zone of entrapment.
The inspector asked the Administrator if other safety issues related to the use of bed rails

addressed, including height and latch reliability. The inspector was provided with a 'preventative maintenance inspection chart' to ensure the proper functioning of the bed. The preventative maintenance included the review of the bed rails to ensure that they were not excessively 'wobbly'. The inspector determined that this document did not support the above safety issues (height and latch reliability).
The inspector reviewed a memo from the Ministry of Health and Long-Term Care dated August 21, 2012 sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document outlines entrapment testing zones, required tools (cone and cylinder, spring scale), side rail height, side rail latch reliability requirements and test methods, mattress compatibility information, other hazards, etc. The documentation provided does not support the prescribed testing.
Therefore, the licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize the risk to the resident, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, and other safety issues related to the use of bed rails are addressed, including height and latch reliability. [s. 15. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. During an interview with inspector #594, resident #0933 stated that a staff member regularly provided rough care to the resident resulting in pain. Resident #0933 stated that they have vocalized their pain and requested the staff member to slow down however the staff member was not receptive to their comments.
Inspector #594 approached staff member #101 to bring forward the statement by resident #0933. Two days later, the inspector interviewed staff member #101 who told the inspector that an investigation had commenced and the Administrator would follow up on November 24, 2014 and submit a Critical Incident Report to the Director. On November 24, 2014 the Administrator requested a date and time that the inspector brought forward the information to staff member #101 in order to submit a report to the Director. Inspector #594 verified a report was then submitted to the Director.
Inspector #594 interviewed the Administrator and staff member #101 who stated that they did not consider the incident abuse thus resulting in the home submitting a report to the Director until approximately 7 days after the incident was reported. The inspector then reviewed the statement resident #0933 had provided to the inspector, which the inspector had previously provided to staff member #101, with the Administrator and staff member #101. Whereby the Administrator stated that they were not aware of the accused staff member's response to resident #0933's vocalization of pain and stated that a report should have been submitted to the Director immediately. Staff member #101 stated that they made notes of the information the inspector provided but did not record the statements resident #0933 provided.
Inspector #594 reviewed the homes Zero Tolerance of Abuse and Neglect Policy reviewed January 2014 which stated that Mandatory Reporting under the LTCHA section 24 (1) requires all persons, including the Home and all staff members, to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur.
Therefore, the licensee has failed to ensure that where reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Inspector #594 reviewed the home's Nursing Pain Management Program Policy reviewed March 2014 which stated that Registered Nursing staff are to implement strategies to effectively manage pain including pharmacological and non-pharmacological interventions and document on the residents care plan. During an interview, resident #5354 and #0933 told the inspector of non-pharmacological pain management interventions effective for them to relieve pain. The inspector reviewed the current electronic care plan for resident #5354 and #0933 and noted that non-pharmacological pain interventions indicated by these residents were not identified. The inspector interviewed staff member #101 who confirmed respective non-pharmacological pain interventions for resident #5354 and #0933 were not documented.
The licensee has failed to ensure that with in respect of the organized pain management program, actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented has been complied with.

Inspector #594 reviewed the home's policy which stated that staff are to document intake and output on a fluid balance sheet if this is being monitored. Resident #0933's current care plan stated that staff are to check urinary output 3x per shift and record amount in mls. Staff #401 and #300 told the inspector that resident #0933's output is documented in the electronic program Point of Care (POC). The inspector reviewed resident #0933 daily flow sheets from POC for approximately 3 months. During this time, there were 17 incidents of undocumented urinary output identified. The inspector interviewed the Administrator who confirmed the missing documentation.
The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented. [s. 30. (2)]

2. Inspector #575 reviewed resident #4910's health care record and determined that staff are to check urinary output every shift. The inspector reviewed resident #4910's daily flow sheets from POC for a period of 9 days. During this time 4 incidents of undocumented urinary output was identified. Inspector #594 reviewed the home's policy which stated that staff are to document intake and output on a fluid balance sheet if this is being monitored.
The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented. [s. 30. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. During a tour of the home, inspector #594 observed the following unlabelled resident personal items:
Resident #3488's shared bathroom: unlabelled toothbrush on bathroom counter;
Resident #5577's shared bathroom: unlabelled comb and toothbrush on counter;
Tub room #1: 3 unlabelled used hair brushes, 1 unlabelled comb in an unlabeled basket, 2 used unlabelled deodorant sticks beside an unlabelled basket;
Tub room #2: 2 used unlabelled hair brushes, 1 unlabelled comb in an unlabelled basket, 4 used unlabelled deodorant sticks;
Tub room #3: 1 used unlabelled hair brush on shelf upon entering room, 2 used unlabelled deodorant sticks, 1 used unlabelled electric shaver, 2 used unlabelled razor blades, 2 used unlabelled combs;
Tub room #4: 3 used unlabelled combs, 3 used unlabelled razors, 4 used unlabelled deodorant sticks, 1 used unlabelled nail scissors;
Tub room #5: 2 unlabelled used combs and 1 used unlabelled deodorant in the shower room.
During an interview, the Administrator told inspector #575 that residents' personal items should be labelled.
Therefore, the licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. During Stage 1 of the inspection, it was identified during a staff interview that resident #1043 had a wound. Inspector #575 reviewed the resident's health care record and noted that approximately 6 months prior, the resident had developed impaired skin integrity and a treatment administration record (TAR) was initiated. Approximately 2 weeks later the treatment record then indicated the same order as previous however now identified the wound as an ulcer. The quarterly Head to Toe Skin Assessment's were reviewed and the inspector noted that 2 quarterly assessments completed after the discovery of the wound indicated that the resident had a Stage 2 pressure ulcer. The home's policy titled 'Skin and Wound Care Program' was reviewed by the inspector. The policy outlined that upon discovery of a pressure ulcer, Registered staff are to 'initiate a baseline assessment using a clinically appropriate assessment instrument (Wound Assessment Flow Sheet)'. The inspector was unable to locate such form in the resident's health care record. On November 20, 2014 the inspector interviewed staff member #200 regarding the resident's wound. The staff member told the inspector that if a resident has a pressure ulcer a tracking form (Wound Assessment Flow Sheet) is used and then indicated that resident #1043 did not have a tracking form and the staff member was not

sure why.
It was not until November 22, 2014 that a Wound Assessment Flow Sheet was initiated for this resident's wound. The Wound Assessment Flow Sheet now identified the type and stage of the ulcer.
The licensee has failed to ensure that resident #1043 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the Registered Nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. During Stage 1 of the inspection, it was identified during a staff interview that resident #1043 had a wound. Through review of the resident's health care record it was determined that the resident's wound was initially noted approximately 6 months prior. The inspector was unable to find a referral to the home's Dietitian regarding the residents wound. Staff member #202 told the inspector that the Physician would refer a resident with a wound to the Dietitian. Staff member #101 told the inspector that Registered staff can refer residents to the Dietitian. The home's policy titled 'Skin and Wound Care Program' identified that the Dietitian is to complete a nutritional and hydration risk assessment within 7 days, recommend/order appropriate diet, supplements and hydration strategies, and make recommendations to physicians including albumin, blood monitoring and vitamins/minerals. The inspector noted that nutritional risk assessments were completed by the Dietitian on a quarterly basis. None of the assessments nor any progress notes by the Dietitian identified that the resident had a wound. In September 2014, the resident was ordered a nutritional supplement for weight loss, with no mention of the current wound. Staff member #101 told the inspector that the Dietitian was aware of the resident's wound because they are on the home's Interdisciplinary Skin and Wound Management Team and provided the inspector with the meeting minutes from September 2014 that identified under 'new business' that the resident had a wound. The meeting minutes provided were months after the wound initially started.
The licensee has failed to ensure that resident #1043 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a Registered Dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented. [s. 50. (2) (b) (iii)]

3. During Stage 1 of the inspection, it was identified during a staff interview that resident #1043 had a wound. The inspector reviewed the health care record and did not locate any weekly re-assessments completed by the registered staff. Staff member #202 told

the inspector that resident #1043's wound is not re-assessed weekly because the dressing is changed daily. The staff member indicated that if the wound was getting worse or if changes needed to be made to the dressing order the Physician or Nurse Practitioner would be notified. The inspector noted that the home's skin and wound assessment instrument (Wound Assessment Flow Sheet) was not initiated until November 22, 2014 almost 6 months after the wound was noted by staff, therefore a re-assessment could not have been completed.
The licensee has failed to ensure that resident #1043 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the Registered Nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

WN #14: 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. During an interview with inspector #594, resident #3788 stated that they were unaware of receiving any written response from the Administrator when concerns or recommendations are addressed. Inspector #594 interviewed staff member #105 who stated that the Administrator provided verbal responses to concerns or recommendations but the staff member was not aware of any written responses. The Administrator verified with inspector #594 that they provided verbal responses but no response in writing within 10 days of receiving Residents' Council concerns or recommendations related to the operation of the home.
The licensee has failed to ensure that when the Residents' Council has advised the licensee of concerns or recommendations, the licensee responds to the Residents' Council in writing within 10 days. [s. 57. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. During an interview with inspector #594, the Administrator and staff member #101 stated that there is no Family Council established at the home due to difficulty recruiting members. Staff member #105 told the inspector that there have been no semi-annual meetings to advise resident families and persons of importance the right to establish a Family Council. Inspector #594 interviewed the Administrator who confirmed that the licensee does not, on an ongoing basis advise the residents' families and persons of importance to residents of the right to establish a Family Council, nor does the home convene semi-annual meetings to advise such persons of the right to establish a Family Council.
The licensee has failed to ensure if there is no Family Council, the home advises the residents' families and persons of importance to the residents' on an ongoing basis of the right to establish a Family Council and convene semi-annual meetings to advise such persons of the right to establish a Family Council. [s. 59. (7)]

WN #16: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. During an interview with inspector #594, resident #3788 stated that menus are reviewed by the Residents' Council but they do not recall meal and snack times being reviewed. Inspector #594 interviewed staff member #105 who stated that they do not review meal and snack times or menus and that food related items are discussed by the FSC with the Residents' Council. During an interview with inspector #594, staff member #103 stated that they do not review meal and snack times with the Residents' Council but that the Administrator provides an annual survey that addresses the meal and snack times. The inspector noted that the Resident Satisfaction Survey required the residents to rate the dining room and meal times as inadequate, adequate, very good or not applicable however, the licensee has failed to review the meal and snack times with the Residents' Council.
The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council. [s. 73. (1) 2.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. Inspector #575 reviewed the home's policy: Use of Restraints reviewed March 2014. The inspector noted that under the section 'Duties and Responsibilities of Staff' the policy outlined that only the Physician, Nurse Practitioner, and Registered Nurse had the authority to apply and release a resident from a physical device to restrain a resident. The inspector confirmed with the Administrator that PSWs are also able to apply and remove restraints and PASDs under the order of the Physician, Nurse Practitioner, or Registered Staff. The inspector noted that the policy did not include the duties and responsibilities of PSWs. Therefore, the licensee has failed to ensure that the 'Use of Restraints' policy address the duties and responsibilities of the staff, including who has the authority to apply or release a physical device. [s. 109. (b) (i)]

2. Inspector #575 reviewed of the home's policy: Use of Restraints reviewed March 2014. The policy outlined that before a restraint is applied, written consent must be obtained using the 'Consent for Restraint Use'. The policy did not outline how consent is to be obtained and documented for the use of a PASD.
The licensee has failed to ensure that the policy addresses how consent is to be obtained and documented for the use of physical devices to restrain (under s. 31) and PASD. [s. 109. (e)]

WN #18: 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. Inspector #575 reviewed the home's processes regarding resident trust accounts. During a family interview, a family member stated that the home has not provided any statements regarding the balance of the resident's trust account. The inspector interviewed staff member #100 regarding the process for notifying resident's and families of the balance of their trust accounts. The staff member told the inspector that quarterly statements are only provided to resident's or families who ask for statements.
Additionally, a review of the home's policy titled 'Resident Trust Accounts' reviewed January 2014 indicated that 'an itemized quarterly statement of money held by the home on behalf of the resident, charges made to the resident, and the balance in the account shall be provided to each resident/authorized representative'.
Therefore, 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. [s. 241. (7) (f)]

Issued on this 10th day of February, 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDSAY DYRDA (575), GILLIAN CHAMBERLIN (593), MONIKA GRAY (594)
Inspection No. / No de l'inspection :	2014_332575_0021
Log No. / Registre no:	S-000480-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 6, 2015
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:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_346133_0004, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for ensuring that all components of the resident staff communication and response system that is in place or that will be put into place 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 may be submitted in writing to Long-Term Care Homes Inspector Lindsay Dyrda at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133. This plan must be received by February 20, 2015 and fully implemented by April 20, 2015.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 15 (2) in that the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. This is specifically related to the home's resident-staff communication and response system.

The home is equipped with a wireless resident-staff communication and response system- Versus Personal Response System. According to the homes policy, each resident is assigned a Personal Response Badge (PAB) upon

admission to the home which is configured in the system and kept current at all times to identify the resident assigned to wear/or use the PAB. The residents' assigned PSW shall ensure that the PAB is worn by the resident at all times and/or secured in a place easily accessible by the resident in his/her room when the resident is not in bed. When a resident is in bed, badges shall be secured in a place where the resident can easily access the badge. In addition, every nursing staff position on each resident home area shall be assigned a PAB. The PAB shall be worn by the designated staff position at all times during a shift. Nursing staff shall verify during their shift that his/her assigned PAB is functioning properly using the badge audit form. Each PSW shall verify during their shift that his/her assigned residents have a working PAB. The "Badge Audit" is completed on day shift and evening shift, activating each resident PAB (resident activates if able), ensuring the dome light illuminates and a page is received.

On each resident unit, all PSW's (with exception to bath PSW's) are to carry a pager which receives calls made from the PAB's. There are also remote pull stations on the walls in resident washrooms and common areas, and calls made from these stations are also received by the pagers carried by the PSW's. The system is not audible however there is a dome light outside each resident room and common area which illuminates indicating where the call was made from. This also allows staff members who are not carrying a pager to identify any residents in need of assistance.

There are numerous sensors installed throughout the home which interact with the Versus Personal Response System. There are sensors located in resident's rooms, resident washrooms, tub rooms and common areas within the home. The sensors should allow the location of the resident to be communicated through the pager to advise the PSW exactly where the resident requiring assistance is. The Versus system allows for a response time report that can be generated for a chosen area and time period within the home. This report shows all calls made during that period, including the time the call was made, the location of where the call was made and the time a staff member responded to the call.

Multiple non-compliances have been previously identified related to this communication and response system:

• During an inspection completed October 2012 under inspection 2012_054133_0041, the two previous compliance orders (CO) were complied

however due to additional system problems an additional CO was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair.

• During an inspection completed September 2013 under inspection 2013_204133_0024 a CO was issued pursuant to the LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued October 2012.

• During an inspection completed December 2013 under inspection 2013_304133_0033 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued September 2013.

• During an inspection completed August 20, 2014 under inspection 2014_346133_0004 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and were linked to previous existing CO's issued December 2013; one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued December 2013.

1. Resident #3264 was unable to place a call when the PAB was first activated November 26, 2014. Furthermore, when the call was then successfully placed, there was a delay in assistance as the call was not received by the pager until 13 minutes after the call was placed.

On November 26, 2014, inspector #593 entered resident #3264's bedroom and observed that their PAB was not visible. It was found that the resident was wearing their PAB under their sweater. The resident was asked to place a call by pressing the button on their PAB. The dome light in the hallway did not illuminate, which indicated that a call had not been made. The resident was asked to press the button on their PAB for a second time and this time the dome

light did illuminate in the hallway, which indicated that a call had been placed. The call was placed at 09:25, however, at 09:39 there was still no response by staff to the call. PSW #406 was located and they confirmed that their pager had received the call, but the time of the call displayed on the pager was 09:38, 13 minutes after the call was actually placed by the resident. The inspector confirmed that PSW #406 had the primary pager for this area.

2. Resident #3264 placed a call November 26, 2014, however when the call was successfully placed the call was not received by the pager until 5 minutes after the call was placed.

On November 26, 2014, inspector #593 requested that resident #1495 place a call by pressing the button on their PAB. The dome light in the hallway illuminated, which indicated that a call was made. A student Nurse responded to the call as they had seen the dome light illuminated in the hallway, however they did not have a pager. PSW #402 then responded to the call and they had a pager. PSW #402 confirmed to the inspector that they had the primary pager for that area. The inspector observed that the pager accurately reflected the location of the call, however the time of the call on the pager was not accurate. The pager indicated that the call was placed at 09:59, when in fact the call was placed at 09:54, five minutes earlier. The inspector reviewed the documented 24 hour PAB checks for November 26, 2014 and noted that the checks for the day shift had been completed by PSW #402 and that it was documented for resident #1495 that "time delay shown when page received".

3. Inspector #593 placed a call from resident #4355's washroom, however there was a delay in assistance as the call was not received by the pager until 5 minutes after the call was placed.

On November 26, 2014, inspector #593 placed a call from resident #4355's washroom at 11:11. The dome light in the hallway was illuminated and flashing, which indicated that a call had been made from the washroom. PSW #403 responded to the call at 11:17 and the location of the call on the pager was correct, however the time on the pager was not correct. The pager indicated that the call was placed at 11:16, five minutes after the call was actually placed. PSW #403 confirmed to the inspector that they had the primary pager for the area, and told the inspector that there is sometimes a delay in the calls being received by the pager.

During an interview with inspector #593 on November 27, 2014, the Administrator was made aware of the issue regarding the delay from the time a call is made until the time the call is received by a pager. The Administrator advised that they were unaware of this issue. The inspector reviewed the home's documented 24 hour PAB checks and noted that on September 05, 2014 on one of the units, it was indicated that there was a nine minute delay from the time a call was placed until the time it was received by the pager. During a previous interview with the Administrator, they advised that these reports were reviewed monthly for any issues with the Versus resident communication system. According to the home's policy: Personal Response System- Overview, the ADOC or Administrator will review the audit forms weekly coordinating with the Maintenance Coordinator to ensure malfunctioning equipment that was documented by the PSW's has been reported and repaired.

Multiple examples of PAB call delays to staff pagers were found during the inspection. This presents a pattern of potential risk to residents in the home should they require urgent assistance from a staff member.

4. Resident #2712 was unable to place a call when their PAB was first activated on November 25, 2014. Furthermore, the resident advised the inspector of earlier problems they encountered when trying to place a call for assistance.

On November 25, 2014 inspector #593 requested resident #2712 to place a call by pressing the button on their PAB. The resident pressed the button however the dome light did not illuminate in the hallway, which indicated that a call had not been made. The resident was asked to press the PAB button once more and the dome light illuminated in the hallway, which indicated that a call had been made and a PSW responded to the call. During this time, resident #2712 advised the inspector that earlier that afternoon they had attempted to place a call at 15:30, however there had been no response from staff after they had pressed their PAB button. The resident then asked their roommate, (resident #003) to place a call (which they did successfully) and a PSW responded to the call. The response time report indicating calls made by residents showed no call placed by resident #2712 around 15:30. During an interview with inspector #593 on November 26, 2014, resident #003 confirmed resident #2712's earlier statement and explanation related to the malfunctioning PAB and confirmed their role in assisting resident #2712 in calling for staff with their own PAB.

5. Resident #1658 was unable to place a call when the PAB was activated twice

November 26, 2014. Furthermore, the resident was unable to locate the PAB on their person and when a call was placed successfully on the third try, the location of the resident on the pager was incorrect.

On November 26, 2014 inspector #593 observed resident #1658 at the puzzle table in the auditorium and noted that their PAB was not visible. Resident #1658 was asked to place a call by pressing the button on their PAB, however the resident could not locate their PAB in order to attempt to make a call. A visitor, who was also seated at the puzzle table, located the resident's PAB which had flipped up and over the resident's shoulder. The PAB had been clipped high up on the residents shoulder. The visitor handed the PAB to the resident as the resident was unable to locate it on their own. The resident pressed the button on the PAB twice and the dome light in the hallway did not illuminate, which indicated that a call had not been made. The resident pressed the PAB button a third time and this time the dome light outside of the auditorium illuminated, which indicated that a call had been made. The resident successfully made a call on their third attempt however as discussed further in CO #002, the location on the pager was incorrect. According to the home's policy: Personal Response System- Overview, each resident's assigned care giver shall be responsible to ensure that the personal response badge is attached to the residents clothing and/or is secured close enough for the resident to reach it in the event of an emergency.

6. Resident #1658's call was not received by the pager on two occasions. However, on both occasions the dome light illuminated which indicated that a call had been successfully made.

On November 27, 2014 the home's Administrator and inspector #593 requested that resident #0425 place a call by pressing the button on their PAB. Resident #0425 was observed to press the PAB button and the dome light outside of their bedroom illuminated, which indicated that a call had been placed. Both pagers for that location were in the possession of the Administrator. Neither pager received a call at this time from resident #0425. The resident was asked to place a second call. The resident pressed the PAB button and the dome light outside of their bedroom illuminated, which indicated that a call had been made. Again, the call was not received by the pagers. The Administrator speculated that the call may not be coming through to the pagers as the resident was covering the PAB sensor with their hand when they were pressing the button. Resident #0425 was asked for a third time to press the button on their PAB and to ensure

that their hand or fingers were not covering the sensor. After the third attempt, the call was received by the pager which displayed the correct time and location. At this time, inspector #593 observed a PSW move the resident's PAB as the resident was having difficulty reaching the PAB where it was currently located, clipped high up on the residents shoulder. As per the home's policy, the badge shall be worn by the resident at all times and/or secured in a place easily accessible by the resident in his/her room when the resident is not in bed.

7. Resident #002 placed a call which was received by the pager however the dome light failed to illuminate which indicated that a call had been placed.

On November 27, 2014 inspector #593 observed the Administrator request that resident #002 make a call by pressing the button on their PAB. The resident was observed to press the button, however the dome light in the hallway did not illuminate. However, the call was received by the primary pager which was being held by the Administrator. The Administrator speculated that the dome light did not illuminate as the resident was wearing their PAB under their sweater. It is to be noted that only minutes earlier, it was observed that resident #0425 covered their PAB sensor with their hand when placing a call and that their bedroom dome light illuminated, however it failed to be received twice by the pagers. As bath PSW's do not carry pagers, they rely on the dome lights to indicate any residents requiring assistance and if the dome light does not illuminate when a call is placed, the PSW's without pagers are unable to identify residents requiring assistance.

8. Resident #4497 placed a call in the dining room which was not received by the pager and the dome light outside of the dining room failed to illuminate.

On November 27, 2014 inspector #593 observed the Administrator request resident #4497, who was in the dining room, place a call by pressing the button on their PAB. The resident was observed to place the call however the dome light outside the dining room did not illuminate nor did the pager receive the call. The Administrator then asked the resident to try again, and as a result of the second attempt, the dome light outside of the dining room illuminated and the call was received by the pager which indicated the correct location. The Administrator noted that the PAB was initially under the resident's apron and speculated that this may be the reason why the call did not go through on the first attempt.

This non-compliance related to the resident-staff communication and response system presents a pattern of on-going potential risk to the residents in the home due to the unreliability of placing calls and calls being successfully received. As such, the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.
(593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 20, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant:
2014_346133_0004, CO #002;
2014_346133_0004, CO #003;

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 prepare, submit and implement a plan for ensuring that the resident-staff communication and response system that is in place or that will be put into place allows calls to be cancelled only at the point of activation and for ensuring that the resident-staff communication and response system that is in place or that will be put into place clearly indicates where the signal is coming from when activated.

This plan may be submitted in writing to Long-Term Care Homes Inspector Lindsay Dyrda at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133. This plan must be received by February 20, 2015 and fully implemented by April 20, 2015.

Grounds / Motifs :

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 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 residents PAB location, the call can only be cancelled in that location. CO #002 therefore addresses intertwined issues under O.Reg, s.17 (1) (c) and s.17 (1) (f).

Multiple non-compliances have been previously identified related to this communication and response system:

• During an inspection completed June 2012 under inspection 2012_054133_0028 two CO's were issued, pursuant to O.Reg 79/10, s. 17. (1) (b) the licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

• During an inspection completed December 2013 under inspection 2013_304133_0033 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued September 2013.

• During an inspection completed August 20, 2014 under inspection 2014_346133_0004 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and were linked to previous existing CO's issued December 2013; one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued December 2013.

1. Resident #0425 was observed to place a call from their room, however the location on the pager indicated that the resident was in the washroom. As a result, staff had to cancel the call from the resident's washroom which was the incorrect location as to where the resident was calling from.

On November 25, 2014 inspector #593 requested resident #0425 to make a call by pressing the button on their PAB. The call was successfully made and PSW #405 responded to the call however the location on the PSW's pager indicated that the resident was in the washroom when in fact the resident was in their bedroom sitting by the window at the time of placing the call.

2. A call was placed by inspector #593 after resident #6355 failed to place a call on two occasions. The placed call did not reflect a location for the resident on the pager. As a result, staff were not required to cancel the call from residents current location.

On November 26, 2014 inspector #593 entered resident #6355's room and requested the resident to place a call by pressing the button on their PAB, which they did. The dome light in the hallway did not illuminate, which indicated that a call had not been placed. Unrelated to this call, the RPN then entered the resident's room to administer medications. After the RPN left, the resident was asked to once again press the button on their PAB to place a call. The resident pressed the button two more times and the dome light did not illuminate in the hallway, which indicated again that a call had not been made. Inspector #593 then pressed the button on the PAB to place the call and this time the dome light in the hallway did illuminate, which indicated that a call had been made. The bath PSW responded as they saw the dome light illuminated in the hallway, however they did not have a pager and therefore went to locate a PSW with a pager. PSW# 402 then attended the call as a result of the bath PSW. The inspector observed PSW #402's pager and noted that a call from resident #6355's PAB was registered, but the location of the PAB at the time of the call was not reflected. When asked by the inspector how the resident would be located, PSW #402 responded that they knew where the resident was at that time as a result of the bath PSW advising them, however usually the call details on the pager showed the location of the resident.

3. After two failed attempts, a call was placed by resident #1658. The call was received by the pager, however the location displayed on the pager was incorrect and did not reflect where the resident was when they placed the call.

On November 26, 2014 inspector #593 observed resident #1658 at the puzzle table in the auditorium. Resident #1658 was asked to place a call by pressing the button on their PAB. After two failed attempts, the resident placed a call and the light outside of the auditorium illuminated, which indicated that a call had

been made. PSW #402 responded to the call. The inspector noted that the call time on the pager was correct, however the location indicated that the resident was in the elevator lobby which is outside of the auditorium. PSW #402 speculated that this was because the resident was closer to the sensor in the elevator lobby. Inspector #593 observed that the resident was seated directly under a sensor in the auditorium which was in fact closer than the sensor in the elevator lobby. A CO was previously issued under inspection 2014_346133_0004 completed August 20, 2014 related to calls placed by residents in the auditorium. Calls from the auditorium showed on the pager as being placed in the elevator lobby, therefore the calls had to be cancelled in the elevator lobby as the location on the pager was incorrect.

During an interview with inspector #593 on November 27, 2014 the Administrator speculated that the elevator lobby sensor may have picked up resident #1658's PAB signal on their way through to the auditorium. Inspector #593 pointed out that the PAB activity report for this period accurately reflected that the resident was in the auditorium when the call was placed. The Administrator was unable to explain this.

4. Residents #002 and #6355 were observed to be wearing their PAB's under their sweaters. According to the home's policy, the impact of not having the PAB visible is that the location reflected on the pager will be of the last location that the PAB was picked up by the sensor, which may not accurately reflect the location of the resident.

On November 26, 2014 inspector #593 entered resident #002's room and observed that their PAB was not visible. The resident showed that their PAB was under their sweater. Shortly after, inspector #593 entered resident #6355's room and observed that the PAB was not visible as the resident was also wearing it under their sweater.

During an interview with inspector #593 on November 26, 2014, the Administrator advised that some residents prefer to wear their PAB's under their sweaters and this is documented in the resident's plan of care. A review of resident #3264, #6355 and #002's plans of care found no mention of the resident's preference for wearing their PAB underneath their sweater. In all three care plans, the only detail regarding the PAB was to "ensure badge is attached to clothing at all times". According to the home's policy: Personal Response System- Overview, the impact of not having the PAB visible is that the location

reflected on the pager will be of the last location that the PAB was picked up by the sensor which may not accurately reflect the location of the resident. The policy also stated that it is important to ensure that badges are not covered up and remain proper side up at all times.

This non-compliance related to the resident-staff communication and response system presents a pattern of on-going potential risk to residents in the home due to the unreliability of the system. For the call to be cancelled, staff members must enter the area displayed on the pager with their PAB. Therefore, if the location displayed on the pager is incorrect, the staff member must go to that displayed location to cancel the call instead of the location where the resident requesting assistance actually is. As such, the licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that allows calls to be canceled only at the point of activation.
(593)

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 a resident-staff communication and response system that clearly indicates where the signal is coming from.

Multiple non-compliances have been previously identified related to this communication and response system:

• During an inspection completed June 2012 under inspection 2012_054133_0028 two CO's were issued, pursuant to O.Reg 79/10, s. 17. (1) (b) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times.

• During an inspection completed December 2013 under inspection 2013_304133_0033 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1) the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued September 2013.

• During an inspection completed August 20, 2014 under inspection 2014_346133_0004 two CO's were issued pursuant to O.Reg 79/10, s. 17. (1)

the licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times; and were linked to previous existing CO's issued December 2013; one CO issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.15. (2) the licensee failed to ensure the resident-staff communication and response system is in a good state of repair, and was linked to the previous existing CO issued December 2013.

1. Resident #0425 was observed to place a call from their room however the location on the pager indicated that the resident was in the washroom.

On November 25, 2014 inspector #593 requested resident #0425 to make a call by pressing the button on their PAB. The call was successfully made and PSW #405 responded to the call, however the location on the PSW's pager indicated that the resident was in the washroom when in fact the resident was in their bedroom sitting by the window at the time of placing the call.

2. A call was placed by inspector #593 after resident #6355 failed to place a call on two occasions. The placed call did not reflect a location for the resident on the pager.

On November 26, 2014 inspector #593 entered resident #6355's room and requested the resident to place a call by pressing the button on their PAB, which they did. The dome light in the hallway did not illuminate, which indicated that a call had not been placed. Unrelated to this call, the RPN then entered the residents' room to administer medications. After the RPN left, the resident was asked to once again press the button on their PAB to place a call. The resident pressed the button two more times and the dome light did not illuminate in the hallway, which indicated again that a call had not been made. Inspector #593 then pressed the button on the PAB to place the call and this time the dome light in the hallway did illuminate, which indicated that a call had been made. The bath PSW responded as they saw the dome light illuminated in the hallway, however they did not have a pager and therefore went to locate a PSW with a pager. PSW #402 then attended the call as a result of the bath PSW. The inspector observed PSW #402's pager and noted that a call from resident #6355's PAB was registered, but the location of the PAB at the time of the call was not reflected. When asked by the inspector how the resident would be located, PSW #402 responded that they knew where the resident was at that time as a result of the bath PSW advising them, however usually the call details on the pager showed the location of the resident.

3. A call was placed by Resident #1658 after two failed attempts. The call was received by the pager, however the location displayed on the pager was incorrect and did not reflect where the resident was when they placed the call.

On November 26, 2014 inspector #593 observed resident #1658 at the puzzle table in the auditorium. Resident #1658 was asked to place a call by pressing the button on their PAB. The resident placed a call and the light outside of the auditorium illuminated, which indicated that a call had been made. PSW #402 responded to the call. The inspector noted that the call time on the pager was correct, however the location indicated that the resident was in the elevator lobby which is outside of the auditorium. PSW #402 speculated that this was because the resident was closer to the sensor in the elevator lobby. Inspector #593 observed that the resident was seated directly under a sensor in the auditorium which was in fact closer than the sensor in the elevator lobby. A CO was previously issued under inspection 2014_346133_0004 completed August 20, 2014 related to calls placed by residents in the auditorium. Calls from the auditorium showed on the pager as being placed in the elevator lobby therefore the pager did not reflect the correct location of the resident.

During an interview with inspector #593 on November 27, 2014 the Administrator speculated that the elevator lobby sensor may have picked up resident #1658's PAB signal on their way through to the auditorium. Inspector #593 pointed out that the PAB activity report for this period accurately reflected that the resident was in the auditorium when the call was placed. The Administrator was unable to explain this.

4. Residents #002 and #6355 were observed to be wearing their PAB's under their sweaters. According to the home's policy the impact of not having the PAB visible is that the location reflected on the pager will be of the last location that the PAB was picked up by the sensor, which may not accurately reflect the location of the resident.

On November 26, 2014 inspector #593 entered resident #002's room and observed that their PAB was not visible. The resident showed that their PAB was under their sweater. Shortly after, inspector #593 entered resident #6355's room and observed that the PAB was not visible as the resident was also wearing it under their sweater.

During an interview with inspector #593 November 26, 2014, the Administrator advised that some residents prefer to wear their PAB's under their sweaters and this is documented in the resident's plan of care. A review of resident #3264, #6355 and #002's plan of care found no mention of the resident's preference for wearing their PAB underneath their sweater. In all three care plans, the only detail regarding the PAB was to "ensure badge is attached to clothing at all times". According to the home's policy Personal Response System- Overview, the impact of not having the PAB visible is that the location reflected on the pager will be of the last location that the PAB was picked up by the sensor which may not accurately reflect the location of the resident. The policy also stated that it is important to ensure that badges are not covered up and remain proper side up at all times.

This non-compliance related to the resident-staff communication and response system presents a pattern of on-going potential risk to residents in the home due to the unreliability of the system reflecting the location of the resident when a call has been placed. As such, the licensee has failed to ensure that there is a resident-staff communication and response system that clearly indicates when activated where the signal is coming from. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 20, 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 6th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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