Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 5, 2015	2015_380593_0013	S-000581-14, 582-14, 717-15, 716-15	Follow up

Licensee/Titulaire de permis

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

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

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

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 19 - 22, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nursing Staff, Dietary Staff, Activation Staff, Maintenance Staff, Personal Support Workers (PSW) and residents.

The inspector also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, tested the resident-staff communication and response system, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #002	2014_332575_0021	593
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2014_283544_0026	593
O.Reg 79/10 s. 53. (1)	CO #001	2014_283544_0026	593

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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: Personal Response System Overview dated March 2014, 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 is 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 PSWs (with exception of bath PSWs) are to carry a pager which receives calls made from the PABs. 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 PSWs. 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 is a primary pager for each resident area, if that PSW staff member allocated for that resident area is unable to respond to the call, the system will automatically page a second staff member within a preset time period. There are numerous sensors installed throughout the home which interact with the Versus Personal Response System. There are sensors located in residents 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.

• During an inspection completed November 28, 2014 under inspection 2014_332575_0021 one CO was 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 allows calls only to be cancelled at the point of activation and clearly indicates where the signal is coming from; and were linked to previous existing CO's issued August 2014; 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 August 2014.

1. Resident #007 was unable to place a call when the PAB was first activated three consecutive times.

On May 21, 2015, Inspector #593, along with the Administrator and the Maintenance Coordinator observed resident #007 in their bedroom, the resident was observed to be wearing the PAB under their sweater. The Administrator requested that resident #005 place a call by pressing the button on their PAB. The dome light in the hallway was illuminated, however the call was not received by either pager. This was repeated two more times without either call being received by the pagers. At this time, resident #007 advised that their PAB does not always work and sometimes when they need assistance at night, they cannot place a call. A fourth test of the PAB was received by the pager. The Administrator advised that the reason the initial calls were not received, may have been because the resident was wearing the badge under their sweater. A review of the home's policy: Personal Response System Overview dated March 2014 found that if a PAB is covered up for some reason, a call will always be initiated by the radio frequency signal. The system will only know the location where the badge was last seen by the infrared sensors.

2. An initial call was not received when the PAB was first activated for resident #008.

On May 21, 2015, Inspector #593, along with the Administrator and the Maintenance Coordinator, observed resident #008 in their bedroom asleep, the Administrator entered the room and placed a call by pressing the resident's PAB. The dome light was not

illuminated and the call was not received by either pager. A second test of the PAB by resident #008 was received by the pager.

3. Resident #009 was unable to place a call when the PAB was first activated three consecutive times.

On May 21, 2015, Inspector #593, along with the Administrator and the Maintenance Coordinator observed resident #009 in their bedroom. The Administrator requested that resident #005 place a call by pressing the button on their PAB. The dome light in the hallway was illuminated, however the call was not received by either pager. This was repeated two more times without either call being received by the pagers. The Administrator advised that there must be something wrong with the resident's PAB. The Administrator then pressed the PAB for Resident #010 who was located in the same room. The dome light in the hallway was illuminated however the call was not received by either pager.

A fourth test was then undertaken on resident #009's PAB, the dome light in the hallway was illuminated and the call was received by the pager. A second test was undertaken on resident #010's PAB, again the dome light in the hallway was illuminated however the call was not received by either pager. The Administrator advised that there must be something wrong with the pager however a test was done with another resident's PAB in a different room location and the call was successfully received by the first pager.

4. A call was placed on resident #011's behalf, the call was not received by the primary pager however the second pager received the call three minutes after the call was placed but the message received was incomplete, including the location of the resident.

On May 21, 2015, Inspector #593, along with the Administrator and the Maintenance Coordinator, observed resident #011 in their bedroom asleep, the Administrator entered the room and placed a call by pressing the resident's PAB. The call was not received by the primary pager for that location, after three minutes the call was received by the second pager however the message on the pager was incomplete including the location of the resident. The Administrator advised that the primary pager for that location was not working, it was observed to have a piece of tape over it and several of the buttons were loose.

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. [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. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to respond to these behaviours and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Resident #002 was observed to exhibit numerous responsive behaviours by Inspector #593:

• Resident #002 was observed exhibiting responsive behaviours toward another resident in one of the home's units. #S-101 was observed to intervene and try to redirect resident #002 away from the other resident. Two additional staff members came to assist in redirecting the resident. Resident #002 was observed to display responsive behaviours toward #S-101 as they were trying to intervene. After several minutes, the resident was redirected. Resident #002 was then observed to try entering a locked area. The resident tried numerous times to open the door displaying responsive behaviours as they were

becoming frustrated that the door would not open.

• The residents in one of the home's units were observed to be seated in the dining room for supper. Resident #002 was not in the dining room at this time and was located in another resident's room. Resident #002 was observed to be displaying responsive behaviours. The RPN was observed to enter the room and try to redirect the resident to the dining room. Resident #002 refused and after a few minutes, the RPN left the resident.

A review of resident #002's progress notes found a pattern of responsive behaviours since admission. The progress notes indicated a pattern of escalation with an increase in frequency.

A review of resident #002's health care record found an e-mail from a specialist service related to an assessment that was completed. During this assessment, documentation monitoring was implemented. The e-mail indicated that a follow up was going to occur shortly after. There was no documentation found related to a follow- up; this was confirmed by the ADOC.

A review of resident #002's health care record found a letter from resident #002's geriatrician to the consulting specialist as resident #002 was in their care at this time. Resident #002's behaviours were described in the letter as well as strategies including trial medication adjustments, continuation of the behavioural management strategies implemented by the previous facility as well as implementation of documentation monitoring. The overall assessment by the geriatrician, concluded prominent responsive behaviours.

A review of resident #002's health care record found a subsequent letter from resident #002's geriatrician regarding resident #002's behaviours. The letter was addressed to resident #002's regular physician as the consultant specialist would no longer see resident #002 as a patient as confirmed by the ADOC due to behavioural specialist nursing resources available to the home. The geriatrician made trial medication adjustments however regarding direction for care staff, the directive was to continue with a gentle persuasion approach (GPA) and the resident's behavioural management plan. The overall assessment by the geriatrician, concluded persisting, significant responsive behaviours.

As documented by the geriatrician, behaviours worsened from admission until the last

assessment completed. Furthermore, there were no records located in the resident's health care record relating to the documentation recommendations from the specialist service assessment.

A review of resident #002's MDS assessments found a worsening in behaviours from admission to the most recent assessment. Most recently, change in mood was documented as deteriorated.

During an interview with Inspector #593 May 20, 2015, #S-101 advised that resident #002's behaviours were much worse at a particular time of day. They added that they believed that behaviour management was being addressed currently by the home. The staff also stated that the behaviours have been getting worse since admission. S#-101 advised that they have not been instructed on what they should do to manage these behaviours.

During an interview with Inspector #593 May 21, 2015, #S-105 stated that resident #002's best time is at a certain time of day but then this changes very easily. #S-105 added that a particular nurse is no longer working and without this resource, the consulting specialist would not see resident #002 as a patient. Resident #002 is seen by a geriatrician which is based on a referral from the home. Regarding involvement from additional services, when they initiated resident #002 being admitted to the home and if the home wants further involvement from this service, they need to send a referral. Regarding managing the behaviours, #S-105 advised that one person will try to deal mostly with resident #002 and they try to keep it this way.

During an interview with Inspector #593 May 21, 2015, #S-106 advised that resident #002's behaviours are significantly worse at a certain time of the day. Resident #002 can change very quickly from being very sweet to displaying prominent responsive behaviours. #S-106 added that there have been some medication adjustments however they have not seen an improvement in behaviours. #S-106 further reported that they have two new residents in the same unit which has made the situation worse as the interactions make resident #002's behaviours worse. Other residents usually do not mind or realize when resident #002 has an interaction with them. #S-106 advises that they have not been given any interventions by the home in dealing with these behaviours, they just work together as a team and see what works. The resident takes up a lot of time on a particular shift in trying to manage their behaviours.

During an interview with Inspector #593 May 21, 2015, the ADOC advised that since

admission, resident #002's behaviours have worsened and the initial behaviour management strategies seem to not be working. It has also become more difficult recently due to the admission of two additional residents in the same unit. The ADOC further added that resident #002 got into an altercation with one of these residents the other night. Regarding use of external resources, the doctor is to make a referral and then the resident will be assessed by external resources. Since the documentation of interventions was implemented, the geriatrician made medication adjustments as a result. The ADOC further added that the behaviour management recommendations in the care plan are from the previous facility that he was in before admission to the home.

A review of resident #002's health care record found three entries for Responsive Behaviour Debriefing Tools used as a behaviour assessment:

• An altercation occurred with another resident. The assessment concluded that the interventions in the care plan were not successful in dealing with this behavioural episode.

• An altercation occurred with another resident. The assessment concluded that the interventions in the care plan were not successful in dealing with this behavioural episode.

• An altercation occurred with another resident. The assessment did not indicate whether the interventions in the care plan were successful in dealing with this behavioural episode.

A review of resident #002's initial care plan found several behavioural interventions to manage their behaviours including possible triggers to the resident's behaviour. The resident's current care plan found no triggers documented regarding resident #002's behaviours except to modify the environment to prevent situations that trigger inappropriate behaviour. The interventions documented in the current care plan were similar to the interventions in place at time of admission to the home.

As evidenced by observations, documented progress notes and staff interviews, resident #002 has prominent responsive behaviours which the home has been aware of since admission, the behaviours are escalating and increasing in frequency and the resident poses a safety risk to themself and other residents. The current care plan has interventions to address these behaviours however, there has been ad-hoc re-assessment of the resident and their behaviours and as confirmed in documented

assessments and in staff interviews, the current interventions are not working. [s. 53. (4)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident sets out the planned care for that resident specifically related to Personal Alert Badge (PAB) placement preference.

Inspector #593 observed on a day in May, 2015, resident #005 with their PAB attached to an device that the resident uses. A review of the resident's current care plan found the following intervention: ensure badge is clipped to clothing.

Inspector #593 observed on a day in May, 2015, resident #004 with their PAB attached to a device that the resident uses. #S-104 advised that the resident prefers to wear it on this device rather than attached to their shirt. A review of resident #004's current care plan found that the badge is to be attached to clothing at all times.

Inspector #593 observed on a day in May, 2015, resident #006 with their PAB attached to a device that the resident uses. A review of the resident's current care plan found no mention of the PAB placement.

During an interview with Inspector #593 May 22, 2015, the ADOC advised they are aware that some residents have their PABs on pieces of equipment and that this is the residents' preference. The ADOC further added that if this is the residents' preference, then it should be included in their care plan.

During an interview with Inspector #593 May 22, 2015, the Administrator advised that anytime a resident does not wear the PAB in the usual area, which is the front of their shirt, then it should be documented in their care plan.

A review of the home's Policy: Personal Response System- Overview dated March 2014, found that 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. Preferably, the badge will be clipped to the front of a resident's clothing near the shoulder area and must not have other clothing placed over top. [s. 6. (1) (a)]

Issued on this 28th day of August, 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) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2015_380593_0013
Log No. / Registre no:	S-000581-14, 582-14, 717-15, 716-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 5, 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 Loach

To CORPORATION OF THE TOWN OF KIRKLAND LAKE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_332575_0021, 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 Corporation of the Town of Kirkland Lake shall prepare, submit and implement a plan for ensuring that all components of the resident staff communication and response system is in a good state of repair, with a focus on ensuring that the resident- staff communication and response system operates consistently and reliably ensuring that notification is received promptly by the system to alert staff to the residents request for assistance.

The plan shall address, but is not limited to, the following points:

a) The licensee shall ensure a resident-staff communication and response system is in place that functions consistently and reliably ensuring that every resident in the home is able to place a call successfully on the first attempt.

b) The licensee shall ensure that the resident-staff communication and response system functions consistently and reliably ensuring that there are no delays between the time of the call being placed by the resident and the time of the call being received by the staff member.

c) The licensee shall ensure that the resident-staff communication and response system is in a good state of repair and functioning as intended.

d) Residents who are identified as being unable to place a call successfully or show difficulty with placing a call using the chosen system are to be provided with an alternative means of placing a call.

This plan may be submitted in writing to Long-Term Care Homes Sudbury SAO Manager Wendy Beauparlant at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the Manager's attention at (705) 564-3133. This plan must be received by August 21, 2015 and fully implemented by October 21, 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 home's

policy: Personal Response System Overview dated March 2014, 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 is 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 PSWs (with exception of bath PSWs) are to carry a pager which receives calls made from the PABs. 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 PSWs. 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 is a primary pager for each resident area, if that PSW staff member allocated for that resident area is unable to respond to the call, the system will automatically page a second staff member within a preset time period. There are numerous sensors installed throughout the home which interact with the Versus Personal Response System. There are sensors located in residents 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.

• During an inspection completed November 28, 2014 under inspection 2014_332575_0021 one CO was 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 allows calls only to be cancelled at the point of activation and clearly indicates where the signal is coming from; and were linked to previous existing CO's issued August 2014; 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 August 2014.

1. Resident #007 was unable to place a call when the PAB was first activated three consecutive times.

On May 21, 2015, Inspector #593, along with the Administrator and the Maintenance Coordinator observed resident #007 in their bedroom, the resident was observed to be wearing the PAB under their sweater. The Administrator requested that resident #005 place a call by pressing the button on their PAB. The dome light in the hallway was illuminated, however the call was not received by either pager. This was repeated two more times without either call being received by the pagers. At this time, resident #007 advised that their PAB does not always work and sometimes when he needs assistance at night, he cannot place a call. A fourth test of the PAB was received by the pager. The Administrator advised that the reason the initial calls were not received, may have been because the resident was wearing the badge under his sweater. A review of the home's policy: Personal Response System Overview dated March 2014 found that if a PAB is covered up for some reason, a call will always be initiated by the radio frequency signal. The system will only know the location where the badge was last seen by the infrared sensors.

2. An initial call was not received when the PAB was first activated for resident #008.

On May 21, 2015, Inspector #593, along with the Administrator and the Maintenance Coordinator, observed resident #008 in their bedroom asleep, the Administrator entered the room and placed a call by pressing the residents PAB. The dome light was not illuminated and the call was not received by either pager. A second test of the PAB by resident #008 was received by the pager.

3. Resident #009 was unable to place a call when the PAB was first activated three consecutive times.

On May 21, 2015, Inspector #593, along with the Administrator and the Maintenance Coordinator observed resident #009 in their bedroom. The Administrator requested that resident #005 place a call by pressing the button on their PAB. The dome light in the hallway was illuminated, however the call was not received by either pager. This was repeated two more times without either call being received by the pagers. The Administrator advised that there must be something wrong with the resident's PAB. The Administrator then

pressed the PAB for Resident #010 who was located in the same room. The dome light in the hallway was illuminated however the call was not received by either pager.

A fourth test was then undertaken on resident #009's PAB, the dome light in the hallway was illuminated and the call was received by the pager. A second test was undertaken on resident #010's PAB, again the dome light in the hallway was illuminated however the call was not received by either pager. The Administrator advised that there must be something wrong with the pager however a test was done with another resident's PAB in a different room location and the call was successfully received by the first pager.

4. A call was placed on resident #011's behalf, the call was not received by the primary pager however the second pager received the call three minutes after the call was placed but the message received was incomplete, including the location of the resident.

On May 21, 2015, Inspector #593, along with the Administrator and the Maintenance Coordinator, observed resident #011 in their bedroom asleep, the Administrator entered the room and placed a call by pressing the resident's PAB. The call was not received by the primary pager for that location, after three minutes the call was received by the second pager however the message on the pager was incomplete including the location of the resident. The Administrator advised that the primary pager for that location was not working, it was observed to have a piece of tape over it and several of the buttons are loose.

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. [s. 15. (2) (c)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under r.53 (4) of the LTCHA. This plan is to include:

Strategies to ensure that for resident #002 demonstrating responsive behaviours:

* The triggers are identified
* Strategies are developed and implemented to respond to the behaviours
* Actions are taken to respond to the needs of resident #002, including assessment, reassessment and interventions
* Communication of the identified triggers and interventions to all staff who provide care and assistance to resident #002
* Documented actions to ensure that all residents are protected from resident #002 when demonstrating responsive behaviours

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St Ottawa, Level 4, K1S 3J4. Alternatively, the plan may be e-mailed to the inspector's at gillian.chamberlin@ontario.ca. This plan must be received by August 21, 2015 and fully implemented by August 31, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that strategies are developed and implemented to respond to these behaviours and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Resident #002 was observed to exhibit numerous responsive behaviours by Inspector #593:

• Resident #002 was observed exhibiting responsive behaviours toward another resident in the living area in one of the home's units. #S-101 was observed to intervene and try to redirect resident #002 away from the other resident. Two additional staff members came to assist in redirecting the resident. Resident #002 was observed to display responsive behaviours toward #S-101 as they were trying to intervene. After several minutes, the resident was redirected. Resident #002 was then observed to try entering a locked area. The resident tried numerous times to open the door displaying responsive behaviours as they were becoming frustrated that the door would not open.

• The residents in one of the home's units were observed to be seated in the dining room for supper. Resident #002 was not in the dining room at this time and was located in another resident's room. Resident #002 was observed to be displaying responsive behaviours. The RPN was observed to enter the room and try to redirect the resident to the dining room. Resident #002 refused and after a few minutes, the RPN left the resident.

A review of resident #002's progress notes found a pattern of responsive behaviours since admission. The progress notes indicated a pattern of escalation with an increase in frequency.

A review of resident #002's health care record found an e-mail from a specialist service related to an assessment that was completed. During this assessment, documentation monitoring was implemented. The e-mail indicated that a follow up was going to occur shortly after. There was no documentation found related to a follow- up; this was confirmed by the ADOC.

A review of resident #002's health care record found a letter from resident #002's geriatrician to the consulting specialist as resident #002 was in their care at this time. Resident #002's behaviours were described in the letter as well as strategies including trial medication adjustments, continuation of the behavioural

management strategies implemented by the previous facility as well as implementation of documentation monitoring. The overall assessment by the geriatrician, concluded prominent responsive behaviours.

A review of resident #002's health care record found a later dated letter resident #002's geriatrician regarding resident #002's behaviours. The letter was addressed to resident #002's regular physician as the consultant specialist would no longer see resident #002 as a patient as confirmed by the ADOC due to appropriate nursing resources available to the home. The geriatrician made trial medication adjustments however regarding direction for care staff, the directive was to continue with GPA and the resident's behavioural management plan. The overall assessment by the geriatrician, concluded persisting, significant responsive behaviours.

As documented by the geriatrician, behaviours worsened from admission until the last assessment completed. Furthermore, there were no records located in the resident's health care record relating to the documentation recommendations from the specialist service assessment.

A review of resident #002's MDS assessments found a worsening in behaviours from admission to the most recent assessment. Most recently, change in mood was documented as deteriorated.

During an interview with Inspector #593 May 20, 2015, #S-101 advised that resident #002's behaviours were much worse at a particular time of day. They added that they believed that behaviour management was being addressed currently by the home. The staff also stated that the behaviours have been getting worse since admission. S#-101 advised that they have not been instructed on what they should do to manage these behaviours.

During an interview with Inspector #593 May 21, 2015, #S-105 stated that resident #002's best time is at a certain time of day but then this changes very easily. #S-105 added that the mental health nurse retired and without this resource, the consulting specialist would not see resident #002 as a patient. Resident #002 is seen by a geriatrician which is based on a referral from the home. Regarding involvement from additional services, they initiated resident #002 being admitted to the home and if the home wants further involvement from this service, they need to send a referral. Regarding managing the behaviours, #S-105 advised that one person will try to deal mostly with resident

#002 and they try to keep it this way.

During an interview with Inspector #593 May 21, 2015, #S-106 advised that resident #002's behaviours are significantly worse at a certain time of the day. Resident #002 can change very quickly from being very sweet to displaying prominent responsive behaviours. #S-106 added that there have been some medication adjustments however they have not seen an improvement in behaviours. #S-106 further reported that they have two new residents in the same unit which has made the situation worse as the interactions make resident #002's behaviours worse. Other residents usually do not mind or realize when resident #002 has an interaction with them. #S-106 advises that they have not been given any interventions by the home in dealing with these behaviours, they just work together as a team and see what works. The resident takes up a lot of time on a particular shift in trying to manage their behaviours.

During an interview with Inspector #593 May 21, 2015, the ADOC advised that since admission, resident #002's behaviours have worsened and the initial behaviour management strategies seem to not be working. It has also become more difficult recently due to the admission of two additional residents in the same unit. The ADOC further added that resident #002 got into an altercation with one of these residents the other night. Regarding use of external resources, the doctor is to make a referral and then the resident will be assessed by external resources. Since the documentation interventions was implemented, the geriatrician made medication adjustments as a result. The ADOC further added that the behaviour management recommendations in the care plan are from the previous facility that he was in before admission to the home.

A review of resident #002's health care record found three entries for Responsive Behaviour Debriefing Tools used as a behaviour assessment:

• An altercation occurred with another resident. The assessment concluded that the interventions in the care plan were not successful in dealing with this behavioural episode.

• An altercation occurred with another resident. The assessment concluded that the interventions in the care plan were not successful in dealing with this behavioural episode.

• An altercation occurred with another resident. The assessment did not indicate

whether the interventions in the care plan were successful in dealing with this behavioural episode.

A review of resident #002's initial care plan found several behavioural interventions to manage their behaviours including possible triggers to the resident's behaviour. The resident's current care plan found no triggers documented regarding resident #002's behaviours except to modify the environment to prevent situations that trigger inappropriate behaviour. The interventions documented in the current care plan were similar to the interventions in place at time of admission to the home.

As evidenced by observations, documented progress notes and staff interviews, resident #002 has prominent responsive behaviours which the home has been aware of since admission, the behaviours are escalating and increasing in frequency and the resident poses a safety risk to themself and other residents. The current care plan has interventions to address these behaviours however, there has been ad-hoc re-assessment of the resident and their behaviours and as confirmed in documented assessments and in staff interviews, the current interventions are not working. [s. 53. (4)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 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 5th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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