Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2013_204133_0024
Log No. / Registre no:	S-001217-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 12, 2013
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) (a)

Linked to Existing Order / Lien vers ordre existant: 2012_054133_0041, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Grounds / Motifs :

1. The home has a wireless resident-staff communication and response system. All residents and all nursing staff members are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. Every nursing staff member is required to wear their badge at all times while on shift. Residents are encouraged to wear their badge at all times. As well, every common area, and all resident washrooms, are equipped with a remote station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to in-coming calls for assistance. Above all resident bedroom and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station. When nursing staff enter the

room to respond to the call, a green light illuminates as the room sensors detect their PAB. The call for assistance is thereby cancelled and the white light turns off. The PABs, remote stations and pagers are battery dependent.

The licensee has failed to comply with O. Reg. 79/10, s.15 (2) c in that the licensee has failed to ensure that the resident-staff communication and response system, which includes the components discussed above, is in a good state of repair. During the follow up inspection, the following evidence was found which demonstrates that the system is not working consistently and reliably. This presents a pattern of risk to the residents of the home.

2. The inspector observed, on September 5th 2013, that resident #001s PAB was not functioning properly. When the inspector initially asked the resident to demonstrate how to make a call, the resident stated that they have had long standing problems with their PAB. Resident #001 said it is not unusual that they attempt to make a call and then go to look outside of their bedroom and see that the white dome light is not illuminated. The resident stated they then go to the nurse station and staff tell them a call has not been received from them. Resident #001 expressed a high level of frustration related to this. The resident was initially successful in making a call with their PAB by pressing the red button many times, forcefully. It should only require one press of the red button to make a call. Subsequent to this, resident #001 and the inspector were unable to produce a call for by pressing the red button on the resident's PAB, while in their bedroom. Later that evening, the Environmental Services Manager (ESM) and inspector noted that resident #001's PAB was, at that time, able to produce a call from the unit dining room, from the bedroom across the hallway, and from the resident's bedroom, but not from within the resident's bathroom, or the bedroom next to theirs. The unit RPN, staff member #S100, tested the PAB with the badge tester, which indicated the battery was ok. The tester cycled up to 3, and staff member #S100 was unsure what that meant, enquiring what the inspector had seen other badges cycle to. This cycling is indicative of signal strength.

Following the initial call made by resident #001 with their PAB, two PSWs (#S101, #S102) came to the resident's bedroom to enquire if they needed assistance. While the green dome light illuminated when they entered the room, the white dome light would not turn off. Staff member #S101 said to the inspector that it is not unusual that the white dome lights do not turn off when

they enter a room, even if the green dome light has illuminated.

3. The inspector observed, on September 5th 2013, that resident #002's PAB was not functioning properly. The inspector asked the resident to demonstrate how to make a call with their PAB, and no call was produced after the resident pressed the red button. The inspector then attempted to make a call, and was successful. Subsequent to this, neither the inspector nor the resident were able to produce another call with the PAB. Staff member #S103, a PSW, was accompanying the inspector at the time and provided the unit emergency PAB to the resident. This PAB was of the same style and the resident was able to produce a call several times. The unit RN, staff member #S104, tested the non-functional PAB with the unit badge tester and it reflected that the battery was ok and it cycled through quickly. The Director of Care, whose office is close to resident #002's bedroom, stated that the resident's PAB had been functioning before lunch time. It was explained to the inspector that the DOC had heard resident #002 banging on their bed rails, and when she went into the resident's bedroom, resident #002 said they had made a call for assistance but staff never came to help them. It was verified that no call had been received by staff. The DOC said that resident #002 was then asked to try their PAB and successfully made a call at that time, and so it was concluded that their PAB was functioning properly.

4. The inspector observed, on September 5th and 6th 2013, that resident #003's PAB was not functioning properly. Working in collaboration with the ESM, the inspector asked resident #003 to demonstrate how to make a call for assistance with their PAB and no call was made after the resident pressed the white button twice and the inspector pressed it twice. The inspector asked the resident if they ever have problems with their PAB and the resident said "I press it often enough but the girls never come". The resident made 2 more attempts and was not successful. The inspector made 2 more attempts and was successful on the second attempt. The resident made 3 more attempts and a call was produced each time. On September 6th, the inspector returned to resident #003 and asked them to try their PAB. Shortly thereafter, staff member #S105, a PSW, came to the bedroom and enquired if the resident required assistance, explaining that their partner's pager (staff member #S106) had received a call from resident #003. The inspector noted that the white dome light above the resident's bedroom door had not illuminated in response to the call. Approximately one hour later, in the company of the ESM and staff member

#S106, a PSW, the inspector returned again to resident #003. Both the resident and the inspector made attempts, but no call was produced by the PAB. Staff member #S106 was carrying both unit pagers at the time and neither reflected a call from resident #003.

When staff member #S105 came to resident #003's bedroom on September 6th (as noted above), they advised the inspector that it was not unusual that resident #003's white dome light, above the bedroom door, does not illuminate when they have made a call for assistance. As well, they informed the inspector that the white dome light does not illuminate above a neighbouring room (L9) when the residents make a call. The inspector proceeded to bedroom L9 and attempted to make a call for assistance from the bathroom remote station. The white dome light did not illuminate and staff did not receive a call on their pagers.

On September 6th, the inspector spoke with staff member #S107, a PSW, whose role on that day was that of bath aid. Staff member #S107 explained their primary duty is to provide baths for the residents, however they are expected to help out by answering calls for assistance from residents, if they have time, in between baths. Staff member #S107 explained they do not carry a pager, and only know if a resident has called if the white dome light is illuminated above a doorway.

5. On September 5th 2013, the inspector worked in collaboration with the ESM and the maintenance aid, and a full audit of the remote call stations in resident bedrooms and common areas was conducted. The remote station in the bathroom for bedroom S5 did not produce a call when first tested, but it did when tested a second time. The remote station in the bathroom for W8 produced a call when the button was pressed but not when the cord was pulled. The remote station in the washroom for L8 could not produce a call. In the shower room in the Lakeshore Care unit, the remote station at the toilet produced a call when the button was pressed but not when the cord was pulled, the remote station at the shower unit could not produce a call. In common resident washroom #2013, on the Teck level, the remote station did not produce a call on the first try but did on the second try. The ESM concluded a new battery was required for the remote stations noted above. The remote station in the bathroom for W9 produced a call, but the white dome light did not illuminate above the bedroom door. It was concluded, by the ESM, that a new light bulb

was needed in this dome light.

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of September, 2013

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

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 12, 2013	2013_204133_0024	S-001217-12	Follow up

Licensee/Titulaire de permis

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

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

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

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 5th and 6th 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of care, the Environmental Services Manager, the maintenance aid, registered and non registered nursing staff and residents

During the course of the inspection, the inspector(s) , in collaboration with the Environmental Services Manager and other staff members, tested various components of the home's resident-staff communication and response system.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home has a wireless resident-staff communication and response system. All residents and all nursing staff members are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. Every nursing staff member is required to wear their badge at all times while on shift. Residents are encouraged to wear their badge at all times. As well, every common area, and all resident washrooms, are equipped with a remote station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to in-coming calls for assistance. Above all resident bedroom and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station. When nursing staff enter the room to respond to the call, a green light illuminates as the room sensors detect their PAB. The call for assistance is thereby cancelled and the white light turns off. The PABs, remote stations and pagers are battery dependent.

The licensee has failed to comply with O. Reg. 79/10, s.15 (2) c in that the licensee has failed to ensure that the resident-staff communication and response system, which includes the components discussed above, is in a good state of repair. During the follow up inspection, the following evidence was found which demonstrates that the system is not working consistently and reliably. This presents a pattern of risk to the residents of the home.

2. The inspector observed, on September 5th 2013, that resident #001s PAB was not functioning properly. When the inspector initially asked the resident to demonstrate how to make a call, the resident stated that they have had long standing problems with their PAB. Resident #001 said it is not unusual that they attempt to make a call and then go to look outside of their bedroom and see that the white dome light is not illuminated. The resident stated they then go to the nurse station and staff tell them a call has not been received from them. Resident #001 expressed a high level of frustration related to this. The resident was initially successful in making a call with their PAB by pressing the red button many times, forcefully. It should only require one press of the red button to make a call. Subsequent to this, resident #001 and the inspector were unable to produce a call for by pressing the red button on the resident's PAB, while in their bedroom. Later that evening, the Environmental Services Manager (ESM) and inspector noted that resident #001's PAB was, at that time, able to produce a call from the unit dining room, from the bedroom across the hallway, and from the resident's bedroom, but not from within the resident's

bathroom, or the bedroom next to theirs. The unit RPN, staff member #S100, tested the PAB with the badge tester, which indicated the battery was ok. The tester cycled up to 3, and staff member #S100 was unsure what that meant, enquiring what the inspector had seen other badges cycle to. This cycling is indicative of signal strength.

Following the initial call made by resident #001 with their PAB, two PSWs (#S101, #S102) came to the resident's bedroom to enquire if they needed assistance. While the green dome light illuminated when they entered the room, the white dome light would not turn off. Staff member #S101 said to the inspector that it is not unusual that the white dome lights do not turn off when they enter a room, even if the green dome light has illuminated.

3. The inspector observed, on September 5th 2013, that resident #002's PAB was not functioning properly. The inspector asked the resident to demonstrate how to make a call with their PAB, and no call was produced after the resident pressed the red button. The inspector then attempted to make a call, and was successful. Subsequent to this, neither the inspector nor the resident were able to produce another call with the PAB. Staff member #S103, a PSW, was accompanying the inspector at the time and provided the unit emergency PAB to the resident. This PAB was of the same style and the resident was able to produce a call several times. The unit RN, staff member #S104, tested the non-functional PAB with the unit badge tester and it reflected that the battery was ok and it cycled through quickly. The Director of Care, whose office is close to resident #002's bedroom, stated that the resident's PAB had been functioning before lunch time. It was explained to the inspector that the DOC had heard resident #002 banging on their bed rails, and when she went into the resident's bedroom, resident #002 said they had made a call for assistance but staff never came to help them. It was verified that no call had been received by staff. The DOC said that resident #002 was then asked to try their PAB and successfully made a call at that time, and so it was concluded that their PAB was functioning properly.

4. The inspector observed, on September 5th and 6th 2013, that resident #003's PAB was not functioning properly. Working in collaboration with the ESM, the inspector asked resident #003 to demonstrate how to make a call for assistance with their PAB and no call was made after the resident pressed the white button twice and the inspector pressed it twice. The inspector asked the resident if they ever have problems with their PAB and the resident said "I press it often enough but the girls never come". The resident made 2 more attempts and was not successful. The

inspector made 2 more attempts and was successful on the second attempt. The resident made 3 more attempts and a call was produced each time. On September 6th, the inspector returned to resident #003 and asked them to try their PAB. Shortly thereafter, staff member #S105, a PSW, came to the bedroom and enquired if the resident required assistance, explaining that their partner's pager (staff member #S106) had received a call from resident #003. The inspector noted that the white dome light above the resident's bedroom door had not illuminated in response to the call. Approximately one hour later, in the company of the ESM and staff member #S106, a PSW, the inspector returned again to resident #003. Both the resident and the inspector made attempts, but no call was produced by the PAB. Staff member #S106 was carrying both unit pagers at the time and neither reflected a call from resident #003.

When staff member #S105 came to resident #003's bedroom on September 6th (as noted above), they advised the inspector that it was not unusual that resident #003's white dome light, above the bedroom door, does not illuminate when they have made a call for assistance. As well, they informed the inspector that the white dome light does not illuminate above a neighbouring room (L9) when the residents make a call. The inspector proceeded to bedroom L9 and attempted to make a call for assistance from the bathroom remote station. The white dome light did not illuminate and staff did not receive a call on their pagers.

On September 6th, the inspector spoke with staff member #S107, a PSW, whose role on that day was that of bath aid. Staff member #S107 explained their primary duty is to provide baths for the residents, however they are expected to help out by answering calls for assistance from residents, if they have time, in between baths. Staff member #S107 explained they do not carry a pager, and only know if a resident has called if the white dome light is illuminated above a doorway.

5. On September 5th 2013, the inspector worked in collaboration with the ESM and the maintenance aid, and a full audit of the remote call stations in resident bedrooms and common areas was conducted. The remote station in the bathroom for bedroom S5 did not produce a call when first tested, but it did when tested a second time. The remote station in the bathroom for W8 produced a call when the button was pressed but not when the cord was pulled. The remote station in the washroom for L8 could not produce a call. In the shower room in the Lakeshore Care unit, the remote station at the toilet produced a call when the button was pressed but not when the cord was

pulled, the remote station at the shower unit could not produce a call. In common resident washroom #2013, on the Teck level, the remote station did not produce a call on the first try but did on the second try. The ESM concluded a new battery was required for the remote stations noted above. The remote station in the bathroom for W9 produced a call, but the white dome light did not illuminate above the bedroom door. It was concluded, by the ESM, that a new light bulb was needed in this dome light.

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

Additional Required Actions:

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

Issued on this 12th day of September, 2013

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

Jessica Lapensée