Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2013	2013_162109_0023	T-88-13/218-13	Complaint

Licensee/Titulaire de permis

Downsview Long Term Care Centre Limited
3595 Keele Street, NORTH YORK, ON, M3J-1M7

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

Downsview Long Term Care Centre
3595 Keele Street, NORTH YORK, ON, M3J-1M7

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

SUSAN SQUIRES (109), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 8, 9, 10, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care Assistant Director of Care, Clinical Coordinator, Registered Nursing staff, family members, residents, Personal Support Workers.

During the course of the inspection, the inspector(s) Conducted a walk through of the care areas and observed the care activities, reviewed the health records for identified residents, reviewed the homes pain management program.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Pain

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who are unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence.

According to 5 PSW's from the day shift and 5 PSW's from the evening shift from 2 Center and 2 East the residents who require a full "hoyer" mechanical lift are not toileted because they do not have the proper slings to enable the staff to put a resident on the toilet and the mechanical lifts do not fit through the bathroom doors.

Record review revealed that resident # 23 has physical limitations and requires the use of a full "hoyer" mechanical lift for all transfers in and out of the wheelchair.

Resident and POA interview conducted on May 22, 2013 indicated that the resident still has the urge to use the toilet and frequently requests to go to the toilet. The POA told the inspector that the resident is not toileted because he/she requires a "full hoyer" lift and the home does not toilet residents who use a full "hoyer" lift. The POA stated that the resident dislikes having to empty bowels and bladder into a brief.

The Personal Support Worker (PSW) staff confirmed that the resident is not toileted because the mechanical lift does not fit through the bathroom door and there is not an appropriate sling available for toileting this resident. [s. 51. (2) (c)]

2. The record review revealed that resident # 24 has physical limitations and requires a full "hoyer" lift for all transfers. According to the PSW staff, the resident recently changed from a sit/stand lift to a full "hoyer" lift. When the resident was using the sit/stand lift, the staff toileted him/her routinely. The PSW stated that presently the resident is not toileted because he/she requires the full "hoyer" lift which does not fit through the bathroom door, and the home does not have appropriate lift slings for toileting residents. The PSW staff said that the resident would use the toilet if offered. [s. 51. (2) (c)]

3. Resident #34 is incontinent of bowel and bladder functions.

The review of the plan of care for toileting indicated that resident #34's brief is checked and changed as required, every morning, before lunch, after supper, at bedtime and two times at night.

The interview with resident #34 indicated that he/she was not encouraged to use containment devices such as the toilet, commode, urinal, bedpan, or some other type of receptacle in which to void or defecate. Resident # 34 told the inspector that he/she would be willing to use a urinal or other receptacle if he/she was offered. [s. 51. (2) (c)]

4. The plan of care for Resident #32 indicates that he/she is incontinent on bladder and bowels. The interview with Resident #32 indicated that resident was not offered to use the toilet when requested.

The written plan of care for toileting indicated that staff needed to respond to toileting request as soon as possible. The interview with PSW stated that Resident #32 gets toileted at least two times a day. The PSW also stated that the resident can hold and will not void or defecate in the brief. The interview with resident confirmed that he/she receives assistance from staff to manage and maintain the bowel continence but not the bladder continence. Resident # 32 who is not able to toilet him/herself independently is not receiving the assistance required to maintain continence. [s. 51. (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. 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. The licensee failed to ensure that the pain management policy and procedure is complied with.

The Pain Management policy # NM-II-P010 includes a pain assessment tool for residents who are unable to communicate their pain or who are cognitively impaired. The policy states that the resident is to be reassessed weekly when they are receiving medication or treatment for pain using the "Pain Flow Record". Neither the pain flow record nor the pain assessment tool is being utilized by the staff for the residents who have communication or cognitive barriers and/or who are taking medication/treatment for pain.

Resident # 16 is cognitively impaired, experiences pain and receives narcotic analgesic twice daily. There is a quarterly pain assessment completed however, according to the registered staff member, the resident is cognitively unable and did not answer the questions regarding the pain as described in the pain assessment form.

In October 2012 resident # 14 resident complained frequently of pain. He/she was prescribed analgesia to be given when required for his/her pain. The resident was given the analgesia at least 8-10 times in the month of October 2012.

According to the resident's family and the staff, the resident is Italian speaking and does not communicate well in English. The quarterly pain assessment was completed in December, 2012 which includes a series of questions about the clinical pain. The answers to the questions indicate that the resident is not in pain however the staff interview indicated that the resident was not able to answer the questions on the pain assessment tool. The home's pain assessment tool for residents with cognitive and/or a communication barrier was not used to assess this resident's pain.

Resident # 17 is prescribed narcotic analgesia three times a day routinely for pain. The resident has a cognitive impairment. The pain assessment tool for cognitively impaired residents was not used for this resident. The weekly pain flow record was not completed to evaluate the resident's pain. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the pain management program is followed by all staff for residents experiencing and being treated for pain, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward any written complaint that have been received concerning the care of a resident or the operation of the home to the Director.

On January 15, 2013 resident # 14's family member submitted a written complaint to the home regarding the care of the resident. The complaint was not forwarded to the Director. [s. 22. (1)]

2. A written complaint was submitted to the home dated March 4, 3013 from the family of resident # 15 regarding care concerns. The complaint was not forwarded to the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any written complaint received concerning the care of a resident or the operation of the home is immediately forwarded to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

In October 2012 resident # 14 resident complained frequently of headache and other body pain. He/she was prescribed analgesia to be given when required for the pain. He/she was given the analgesia at least 8-10 times in the month of October 2012.

According to the resident's family and the staff, the resident is Italian speaking and does not communicate well in English. The quarterly pain assessment was completed in December, 2012 which includes a series of questions about the clinical pain. The answers to the questions indicate that the resident is not in pain however the staff interview indicated that the resident was not able to answer the questions on the pain assessment tool. The resident continued to complain of pain.

The licensee has a clinically appropriate assessment tool which includes non-verbal assessment components which was not used to assess this resident. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee failed to ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg 79/10, s. 100.

The home's policy # 03-04-Complaint Management does not include the following required information:

-investigating and resolving of complaints if possible within 10 days of receipt of the complaint;
-If the complaint alleges harm or risk of harm to one or more resident immediate commencement of an investigation.
-There is no information on the home's policy regarding immediately forwarding any written complaints that have been received concerning the care of a resident or of the operation of the home to the Director. [s. 100.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg 79/10, s. 100, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to respond to a written complaint received by the family of resident # 14 regarding care issues.

On January 15, 2013, the family member emailed a letter of complaint to the Resident Family Resource Worker outlining issues about the care of resident # 14. The Resident Family Resource Worker told the inspector that she forwarded the email to the Director of Care.

The Director of Care responded to another family member and not the actual complainant about his/her concerns. [s. 101. (1) 1.]

2. The licensee failed to respond to the written complaint made regarding the care of resident # 15 indicating what the licensee has done to resolve the complaint or whether the licensee believes that the complaint is unfounded.

On March 4, 2013 the family of resident # 15 wrote a complaint to the home regarding fever, and deteriorating condition, nutritional supplements not given and pain control. [s. 101. (1) 3.]

3. When the licensee receives a complaint from a staff, resident, family or other person regarding the care or operation of the home, they place information into a file folder. There are 10 complaints for 2013 as of May 9, 2013.

There is no indication of the nature of each complaint, whether or not is was verbal or written, the date that the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, every date on which any response was provided to the complainant and a description of the response and any response made by the complainant.

There is no documented record of the following complaints received.

There is no documented record for the following complaints as provided by DOC:
Resident # 19 - complaint related to falls.
Resident # 20 - care concerns. New admission
Resident # 21 - concerns regarding deteriorating condition.
Resident # 22 - complaint about roommate behaviours. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that complaints are investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, 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:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that training in pain management, including pain recognition of specific and non-specific signs of pain are provided to all staff who provide direct care to residents.
The Personal Support Workers and the registered staff members have not received training in pain management in the past year.

This was confirmed with the Director of Care. [s. 221. (1) 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 to ensure that all direct care staff are provided with training in pain management, including pain recognition of specific and non-specific signs of pain, to be implemented voluntarily.

WN #8: 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 failed to ensure that staff use safe transferring and positioning devices or techniques when assisting Residents.

The review of the plan of care for Resident #31 stated that resident uses full "Hoyer" mechanical lift for all transfers. The interview with Registered Practical Nurse confirmed that staff transfers resident either by a sit/stand mechanical lift or a total "Hoyer mechanical lift. The improper lift is being used to transfer this resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the written plan of care gives clear direction to staff and others who provide direct care to the resident. The review of the plan of care for Resident #31 indicates that the brief to be checked and changed in wheelchair, by two people, every morning, evening and one time at night. The interview with resident and registered staff confirmed that staff transfers Resident #31 for toileting purposes using either a total "Hoyer" or sit-stand lift. [s. 6. (1) (c)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any established by the regulations;
3 (e) the long-term care home's procedure or initiating complaints to the licensee.
(h) the name and telephone number of the licensee.

The licensee does not have information for residents and family's who have complaints posted in the home.

There are no names and telephone numbers for the licensee posted in the home for the residents and family members. [s. 79. (1)]

Issued on this 4th day of June, 2013

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SQUIRES (109), SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2013_162109_0023
Log No. / Registre no:	T-88-13/218-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 3, 2013
Licensee / Titulaire de permis :	Downsview Long Term Care Centre Limited 3595 Keele Street, NORTH YORK, ON, M3J-1M7
LTC Home / Foyer de SLD :	Downsview Long Term Care Centre 3595 Keele Street, NORTH YORK, ON, M3J-1M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christiana Burns

To Downsview Long Term Care Centre Limited, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how resident # 23, #24, # 32 and #34 who are unable to toilet independently some or all of the time and require assistance with toileting are assisted to ensure that their continence is managed and maintained.

Please submit compliance plan to susan.squires@ontario.ca by June 7, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that residents who are unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence.

According to 5 PSW's from the day shift and 5 PSW's from the evening shift from 2 Center and 2 East the residents who require a full "hoyer" mechanical lift are not toileted because they do not have the proper slings to enable the staff to put a resident on the toilet and the mechanical lifts do not fit through the bathroom doors.

The written plan of care for toileting resident #32 indicated that staff needed to respond to toileting request as soon as possible. The interview with PSW stated that the resident gets toileted at least two times a day. The PSW also stated that the resident can hold and will not void or defecate in his/her brief. The interview with resident confirmed that resident received assistance from staff to manage and maintain the bowels continence but not bladder continence. Resident # 32 who is not able to toilet him/herself independently is not receiving the assistance required to maintain continence.
(210)

2. The licensee failed to ensure that Resident #34 who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence. The review of the plan of care and interview with staff indicated that resident #34 is toileted by checking and changing the brief as required, every morning, before lunch, after supper, at bedtime and 2 times at night. Resident #34 is incontinent of bowel and bladder functions. The interview with resident #34 indicated that he/she was not encouraged to use a urinal or the toilet to void or defecate. (210)

3. The record review revealed that resident # 24 has physical limitations and he/she requires a full "hoyer" lift for all transfers. According to the PSW staff, the resident recently changed from a sit/stand lift to a full "hoyer" lift. When the resident was using the sit/stand lift, the staff toileted him/her routinely. Presently the PSW stated that the resident is not toileted because he/she requires the full "hoyer" lift which does not fit through the bathroom door, and the home does not have appropriate lift slings for toileting residents. The PSW staff said that the resident would use the toilet if offered.. (109)

4. The plan of care revealed that resident # 23 has physical limitations and requires the use of a full "hoyer" mechanical lift for all transfers in and out of the wheelchair. Resident and POA interview conducted on May 22, 2013 indicated that the resident still has the urge to use the toilet and frequently requests to go to the toilet. The POA told the inspector that the resident is not toileted because he/she requires a "full hoyer" lift and the home does not toilet residents who use a full "hoyer" lift. The POA stated that the resident dislikes having to empty bowels and bladder into a brief.
The Personal Support Worker (PSW) staff confirmed that the resident is not toileted because the mechanical lift does not fit through the bathroom door and there is not an appropriate sling available for toileting this resident.
(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 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

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

and the Director

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
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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 3rd day of June, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN SQUIRES

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