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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Mar 19, 2015	2015_381592_0004	O-001648-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE OTTAWA JEWISH HOME FOR THE AGED
10 Nadolny Sachs Private Ottawa-Carleton ON K2A 4G7

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

HILLEL LODGE
10 NADOLNY SACHS PRIVATE OTTAWA ON K2A 4G7

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

MELANIE SARRAZIN (592), KATHLEEN SMID (161), PAULA MACDONALD (138), WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 2, 3, 4, 5, 6,9, 10, 11, 12 and 13, 2015

It is noted that the follow-up for order Log#O-001113-14 was conducted during and included in this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members,Volunteers, Private Duty Sitter, Chair of Family Council, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Housekeeping Aide(HKP), Pharmacist, Dietitian, Food Service Supervisor, Director of Environmental Services/Coordinator Of Quality Control, Director of Social Work/Program and Support Services, Executive Director,RAI MDS Coordinator, Director of Care and Physiotherapist.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.

14 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Compliance Order pursuant to O.Reg 79/10, s.36 was first issued as a result of Critical Incident Inspection #2014_199161_0026 on November 25, 2014 with a compliance date of February 28, 2015.

The licensee failed to complete education for all staff who are involved in transferring Residents with a mechanical lift specifically:

1. Staff did not complete return a demonstration for their ability to ensure the measurement of a correctly fitting sling and the application of same,

2. Staff did not complete a return demonstration for their ability to safely transfer a Resident as a lift operator on any/all different styles of transfer slings that they may be required to use in the course of their duties.

On March 5, 2015 a follow-up inspection was conducted in conjunction with the Resident Quality Inspection. The Director of Environmental Services/Coordinator of Quality Control (DESCQC) indicated to Inspector #161 that a Clinical Consultant from ArjoHuntLeigh Getinge Group (RHLGG) had been hired to provide the mechanical lift training to the staff and that the first in-service was held on December 15, 2014. Inspector #161 asked the DESCQC for the mechanical lift training in-service records for those staff who attended the education sessions provided by the Clinical Consultant from ArjoHuntLeigh Getinge Group (RHLGG). It is documented that 70 staff attended these in-service education sessions. The Director of Nursing and the DESCQC provided Inspector #161 with the "Nursing Department Employee Report" dated March 2, 2015. The number of nursing staff recorded on mechanical lift training in-service records was then compared to the "Nursing Department Employee Report." It is noted that a total of 70 staff attended the mechanical lift training in-services, while the remaining 22 staff had not attended the mechanical lift training in-services as specified in the Compliance Order dated November 25, 2014. This was verified by the Director of Nursing and the Director of Environmental Services/Coordinator of Quality Control.

On March 5, 2015 Inspector #161 asked the DESCQC for the training content of the mechanical lift in-services provided by the Clinical Consultant RHLGG. The DESCQC provided a document titled "Hillel Lodge Training Content 2014/2015 ArjoHuntLeigh." This document was reviewed by Inspector #161 and it was noted that there was no training content, as specified in the Compliance Order of November 25, 2014, that required staff to (1) complete return demonstration for their ability to ensure the measurement of a correctly fitting sling and the application of same nor, (2)complete return demonstration for their ability to safely transfer a Resident as a lift operator on any/all different styles of transfer slings that they may be required to use in the course of their duties. This was verified by the Director of Environmental Services/Coordinator of Quality Control. On March 6, 2015 during a telephone call, the Clinical Consultant from ArjoHuntLeigh Getinge Group informed Inspector #161 and the Director of Environmental Services/Coordinator of Quality Control that he had not required staff that he had in-serviced to date, to complete return demonstrations as stipulated in the Compliance Order dated November 25, 2014.

On March 5, 2015 discussion held with the Director of Nursing and the DESCQC in which they confirmed that not all required actions were completed as per the initial order. [s. 36.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to receive visitors of his or her choice without interference.

On Tuesday, March 3, 2015 Inspectors noted a sign on a flip chart in the front entrance of the building stating "visitors should be discouraged and if necessary, visits should be kept brief (max 30 mins)". In addition, two signs stating "due to a gastro-intestinal outbreak the lodge is closed until further notice. Visitors should be discouraged and if necessary, visits should be kept brief (maximum 30 minutes)" were located on the glass doors entering the building.

In an interview Resident #014 stated that on Tuesday March 3, 2015 he/she went down to the front door to wait for his/her friends to arrive to play bridge and was told by the receptionist that his/her friends would not be allowed to come and play bridge at the home that day because of the outbreak. The resident was quite upset and did not understand why he/she was not allowed to meet with his/her friends in the home since he/she was not sick and the unit that he/she lived on was not affected by the outbreak.

In an interview the Recreation/Program/Volunteer Manager stated that when the outbreak was declared the DOC gave the direction that there were to be no group activities in the home and therefore the Resident #014 and his/her friends were not permitted to meet in the home to play bridge.

In an interview RN #S108 stated that during an outbreak, families are called and asked not to visit even if their resident is not sick. She further indicated that if a visitor comes anyway, they are stopped at the front desk and they aren't allowed to come into the home.

In an interview RPN #S107 stated that when the home is in outbreak all units are closed even units where there are no infected residents, and all residents have to stay on their units even if they are not sick. Visitors, especially families, are not allowed to come and visit, they receive emails advising them of the outbreak and asking them not to visit. RPN #S107 stated that when the home closes, it is stressful for the residents because they are not allowed to leave and they are not allowed visits from their families. RPN #S107 further stated that if a visitor comes to the front door the receptionist tells them about the outbreak, and they are not allowed to come in unless their loved one is very sick or it is an emergency.

In an interview the DOC stated that they should have been allowed to play bridge on the

resident's unit because that unit had not been affected by the outbreak.

In an interview Resident #018 stated that his/her spouse, Resident #022 live on separate units on the same floor and spend time together during the day, but they have not been able to visit because the unit doors have been closed. The resident stated that neither of them were sick during the outbreak.

In an interview Resident #022 stated that neither of them had been sick during the outbreak. The Resident stated that it has been approximately a week that the doors have been closed and residents have not been allowed to leave the unit. The Resident further stated that normally they spend almost all day together and they normally eat together, but when the outbreak started they were told they were not allowed to eat together until the outbreak was over. The Resident indicated that he/she is finding it stressful, and his/her spouse is really having difficulty accepting the lack of contact. The Resident further told inspector #556 that he/she feels restrained but he/she doesn't have the power to do anything about it.

In an interview RPN #S107 stated Resident #018 is a resident who lives on one side of Resident corridor from the spouse and Resident #022 resides on the other side and that they normally spend time together but since the outbreak they have been cohorted to their units. She further stated that Resident #018 and #022 have not been sick during the outbreak.

In an interview RPN#S112 stated that during an outbreak well residents can mingle with each other but cannot move from unit to unit, or go downstairs to the cafe.

In an interview RN #S109 stated that normally when the home is in outbreak residents are not permitted to move around within the building. [s. 3. (1) 14.]

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 the home is in outbreak every resident’s right to receive visitors of his or her choice without interference is respected., to be implemented voluntarily.

WN #3: 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 LTCHA 2007, S.O. 2007, c.8, s. 15 (2) (a) in that the licensee did not ensure that the home’s furnishings and equipment are kept clean and sanitary.

Inspector #592 observed several soiled Residents’ambulating equipment on March 10, 2015 as follows:

-Resident #021’s walker was observed with accumulation of food debris on the seated black foam cushion and on the wheels. White particles were also observed to hand grips and walker's frame.
-Resident #030 wheelchair frame, cushion and both arm rest were observed with dusty white particles and covered with dry debris.
-Resident #028 walker frame and seated black foam cushion were observed with

accumulation of white particles and dry debris
-Resident #017 wheelchair frame and both sides of the seated cushion were observed with dry food debris.
-Resident #019 walker was observed with food debris crushed on the wheels and wheel base, cushion, and break handles.

During an interview on March 10, 2015 with PSW S#122 on third floor West, she told inspector #592 that resident's ambulating equipment are cleaned by PSW on night shift using the product Oxivir TB. PSW S#122 told inspector #592 that ambulating equipment was also cleaned during their shift as needed with the Oxivir TB wipes. She further indicated that she was not aware of any routine or schedule for the cleaning of the ambulating equipment.

During an interview on March 10, 2015 with PSW S#124 on third floor East, she indicated that PSW were responsible each shift to ensure that the wheelchairs and walkers are being cleaned for each of their assigned Residents.

During an interview on March 10, 2015 with PSW S#123 on third floor East, she indicated that night staff PSW are responsible to clean the resident ambulating equipment. Indicated that the home has no routine or any schedule in place and that staff are expected to clean the ambulating equipment whenever they see that it is dirty. PSW S#123 told inspector #592 that once the ambulating equipement is washed, the PSW signs on a specific sheet. The PSW could not provide this sheet at the time of the interview.

During an interview on March 10, 2015 with the DOC, she indicated that the home process for the cleaning of ambulating equipment was to have the Resident's wheelchair and walkers sent downstairs every night to get cleaned using the "type of steamer dishwasher machine". DOC indicated that the ambulating equipment was scheduled on a rotation to be cleaned on a weekly basis by night staff. She further indicated that the staff were to initial the sheets once it was done but unsure if this was the current practice anymore.

During a second interview on March 11, 2015 with the DOC, she indicated that following the interview, she went on the units and could not find any routine or assignments for the cleaning of the ambulating equipments. DOC further added that she was told by a Nursing staff that the computer software program contained a section for the cleaning of the wheelchairs equipment to be done on a monthly basis but no reference was found in

the section for the walkers.
DOC was unable to indicate when was the last time that the ambulating equipment was cleaned.

She further provided to inspector #592 the Health Care Aide/Personal Support Worker routine for night staff which indicates the cleaning of wheelchairs between 12:00 and 01:00 but no directions for the cleaning of walkers was found. [s. 15. (2) (a)]

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 Resident's wheelchairs and walkers are kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, that the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident

On March 12, 2015, two beds were observed with two quarter rails in the upright position for Resident #017 and #015.

During an interview on March 12, 2015 with PSW S#122 and S#126, both told inspector #592 that it was the home current practice that all residents should have two quarter rails in the upright position, unless resident refuses or full bed rails or in place. PSW S#122 further indicated that Resident #017 and #015 were both able to get in and out of bed and that both Residents were not using the two quarter side rails for repositioning or restraining but for safety purpose only.

During an interview on March 12, 2015 with RPN S#127 she told inspector #592 that all residents were using two quarter rails in the upright position while they were in bed.

During an interview on March 12, 2015 with the DOC, she indicated to inspector #592 that two quarter side rails were being used in the home as these were not considered a restraint. DOC further indicated that the home replaced all of the beds last year and each resident received a bed equipped with two quarter side rails, as they were in the process of reducing the number of full bed rails used in the home. In addition she told inspector #592 that there were no written instructions for the staff to indicate the purpose and when to use the quarter side rails in the upright position for residents. DOC stated that there was no assessment and evaluation of the bed system when the new beds were introduced last year. [s. 15. (1) (a)]

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 residents who use rails in the upright position received an assessment and their bed system evaluated in accordance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During the RQI stage 1 interviews residents’ #027, #026, #012 stated they do not receive beverages mid-morning, and residents #015, #017, #027, #026, and #012 stated they do not receive beverages in the evening.

Inspectors #592 and #556 observed on Third Floor East and West unit during the morning of March 3, 4 and 5 and noted that there was no between-meal beverages distributed to Residents.

In an interview RPN #S112 stated that #S120 does the beverage pass in the morning on all units, and in the afternoon the PSWs do the beverage/snack pass. RPN #S112 further stated that during an outbreak #S120 would not be able to move from unit to unit and therefore that could interfere with the beverage pass getting done if the PSWs don't take over.

Private Sitter #121 stated that during the outbreak there often was no beverage pass, but if a resident asked for a beverage the nurse would provide it.

In an interview #S120 stated for the past 3 months she has been doing the morning beverage pass on all units, however during the outbreak which started on March 03, 2015 she stayed on one unit.

PSW #S106 stated that the beverage pass should be completed by PSWs if #S120 does not come to the unit.

RN #S109 stated that during the outbreak the beverage cart did not get passed in the morning because #S120 usually passes the beverage cart and the PSWs are not used to doing it, however RN #S109 often provides beverages to residents throughout the day.

In an interview the DOC stated that if #S120 does not come to the unit to do the beverage pass the expectation is that the PSW's are to do it. [s. 71. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner is offered to all residents in the home., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labelled and are kept inaccessible to residents at all time.

On March 02, 03 and 06, inspectors #161 and #592 observed in several spa rooms the following:

Spa located on third floor on West unit: spa door left open and unattended with cupboard closed containing three bottles of Citrus 11 Hospital Germicidal Deodorizing Cleaner and two containers of Disinfectant Cleanser IV.

Spa located on third floor on East unit: spa door left open and unattended with cupboard closed containing 5 bottles of Citrus 11 Hospital Germicidal Deodorizing Cleaner and two containers of Disinfectant Cleanser IV.

Spa located on second floor on West unit: spa door left open and unattended with cupboard closed containing 4 bottles of Citrus 11 Hospital Germicidal Deodorizing Cleaner.

As per the product Material Safety Data Sheet, the Disinfectant Cleanser IV product is classified under the Workplace Hazardous Materials Information System classification as a corrosive product under product identification and labelled as being Corrosive.

As per the manufacturer's Safety Data Sheet provided by the Director Of Environmental Services/Coordinator Of Quality Control(DESCQC) the Citrus II Hospital Germicidal Deodorizing Cleaner product as a hazard classification of acute toxicity.

During an interview with HKP S#118 and HKP S#119, both indicated to inspector #592 that all hazardous products used for the cleaning and disinfecting of the home should be kept locked at all times in the janitor’s room or in the housekeeping cart. Both indicated that all the hazardous products were locked due to potential harm to residents.

HKP S#118 accompanied inspector #592 to spa room on third floor East unit and told inspector #592 that it was the home's regular practice to keep both products in the cupboard due to PSW using both products to clean the bath tubs.

HKP S#119 accompanied inspector #592 to spa room on third floor West unit and told inspector #592 that it was the home's regular practice to leave the Citrus II Hospital Germicidal Deodorizing Cleaner and the Disinfectant Cleanser IV not locked in the spa rooms as PSW’s are using these two products for the disinfection of the bath tubs.

During an interview on March 09 2015, with the (DESCQC), she told inspector #592, that the home's regular practice is to leave the Citrus II Hospital Germicidal Deodorizing Cleaner and the Disinfectant Cleanser IV in the spa rooms by exception of the second floor East lock unit because these two products were considered whirlpools products not housekeeping products. Further added that she was told by her vendor that the Citrus II Hospital Germicidal Deodorizing Cleaner was considered a natural product but unsure for the Disinfectant Cleanser IV.

On the same day, DOC told inspector #592 that both products were being removed from the spa rooms and from now own the Citrus II and the Disinfectant Cleaner IV will be kept locked in the Janitor’s room. [s. 91.]

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 hazardous substances are inaccessible to residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the Registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if, the staff member has been trained by a member of the Registered nursing staff in the administration of topicals.

On March 04, 2015 while observing the medication administration on the third floor West unit, RN S#105 told inspector #592 that PSWs were delegated to apply prescribed topical creams to residents and that she was not aware if PSWs had received the training in the application of topical.

During an interview with PSW S#110 and PSW S#111 on March 05, 2015, both indicated to inspector #592 that they were administrating topical cream to their assigned resident and that no training was provided for the administration of topical creams as staff refers to the directions on the labelled container as needed.

During an interview with the Director of Care on March 05, 2015, she told inspector #592 that there was no process in place in the home for the delegation of topical creams to PSWs, therefore no training was ever provided. She told inspector #592 that she was not aware that this practice was occurring on a specified unit. She further told inspector #592 that this was not the expectation from the home and that PSWs were not permitted to administer any topical medication. [s. 131. (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 a member of the Registered Nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if the staff member has been trained., 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 has failed to ensure that there is a written plan of care for Resident #005 that sets out clear directions to staff and others who provide direct care to the resident.

In an interview the private sitter of Resident #005 stated that the resident has some issues with dental care, has already seen the dentist, and there are no plans in place.

A progress note indicated that Resident #005 had some issues with dental care.

A review of the resident health care record indicated that an oral assessment was conducted by MultiGen Health Care on a specific date which indicated the resident should be referred to the Dental Clinic.

In an interview RPN #S112 stated that the resident had seen a dentist and the Substitute Decision Maker did not wish to have a dental treatment done at this time.

RPN #S112 reviewed Resident #005’s plan of care with Inspector #556 and stated that the plan of care does not include any direction for staff and others who provide direct care to the resident for oral care, or any type of assessment. RPN #S112 further stated the registered staff know to check the resident’s mouth every once in a while but that it should definitely be included in the residents plan of care. [s. 6. (1) (c)]

WN #9: 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 comply with section 8 of the regulation in that the licensee failed to comply with its policy related to falls prevention and management.

In accordance with this section and section 30 (1)1, 48(1)1, and 49 of the regulation, the licensee of a long term care home is required to have a falls prevention and management program in place, including relevant policies, to reduce the incidences of falls and the risk of injury.

The inspector reviewed Resident #016 and Resident #015’s health care record as both residents have had a recent fall. Resident #015 had a fall on a specific date, in which the resident’s head was hit resulting in both a laceration and a bump on the head as well as reports of a headache. The resident was immediately sent to hospital and returned to the home within a few hours with sutures to the laceration on the head. The health care record was further reviewed and the inspector could not find any indication that a head injury routine was initiated for the resident upon return to the home. The inspector spoke with an RPN S#127, regarding post fall management and the RPN stated that a head injury routine is to be conducted for all residents that have an unwitnessed fall or a witnessed fall with the potential for head injury. The RPN stated that a head injury routine should have been completed for the above fall for Resident #015 but could not confirm that it had not been initiated, nor could the RPN provide any supporting documentation to demonstrate that the head injury routine had been initiated.

Resident #016 had an unwitnessed fall during the night on a specific date and was found sitting on the floor by staff. The resident’s health care record was further reviewed and the inspector was unable to locate any indication that a head injury routine had been initiated for this specific fall. The inspector spoke with an RPN S #101, regarding this fall

and the RPN could not confirm that a head injury routine had been initiated for this fall for Resident #016, nor could the RPN provide any supporting documentation to demonstrate that the head injury routine had been initiated.

The home's policy on falls prevention and management (Falls Prevention and Management, revised 10/16/11) was provided to Inspector #138 by the Director of Care. This policy was reviewed by the inspector and noted that it directs the multidisciplinary team to initiate a head injury routine during the post fall management of a resident. The inspector spoke with the Director of Care regarding this policy with respect to a head injury routine and the Director of Care stated that a head injury routine should be initiated for any unwitnessed fall and any witnessed fall with the potential for head injury. In addition, the Director of Care stated that a head injury routine would have been expected for Resident #015 upon return from the hospital for the fall on February 18, 2015. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to comply with section 8 of the regulation in that the licensee failed to comply with its policy related to Drug Administration.

In accordance with this section and section s.114 (3) of the regulation, the licensee of a long-term care home shall ensure that the written policies and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

On March 05, 2015 during the process of doing the observation of the Drug Administration for Resident #025 by RN #S108, Lactulose 10GM/15ML: 15ml and Resource 2.0: 60 ml were not prepared and not administered but documented by RN #S108 in the electronic medication record as being given

During an interview on March 05, 2015 with RN S#108, she told inspector #592 that Lactulose and Resource were documented as being given and that it was her current practice to give the lactulose and Resource after the Resident's breakfast. She further added that Resident #025 always takes his/her medications and in the case that Resident refuses them, she would then change her documentation accordingly.

Following the interview, RN S#108 prepared both prescribed medication and went to the dining room with the presence of inspector #592 to administer both medications to Resident #025. Lactulose 15ml was given to Resident #025 during the time of the

observation and Resource 60ml was left on the resident dining table. RN S#108 further told inspector #592 that the Resource will not be given at this time but she was expecting that resident #025 would take the Resource after breakfast.

During an interview on March 10, 2015 with the Director of care, she told inspector #592 that the home's current practice was to have the Registered Staff to remain with the Resident until the medication is taken unless resident feels threatened. She told inspector #592 that Registered Staff can’t signed off in the electronic form if the medication is not taken. In addition she told inspector #592 that she was aware of the Registered Staff not remaining with the resident for the intake of the Resource but thought that the practice was not a concern. She confirmed with inspector #592 that the home was presently referring to Policy Reference Code: Nursing 2011/AM dated on October 21, 2011 for Administration of Medication.

Upon a review of the Home Policy and procedures Manual in the Administration of Medications Policy under Reference code Nursing 2011/AM dated on October 21,2011 under Procedure tab. 7 it is indicated that Registered Staff:

Remain with resident until medication is taken and under tab. 8 it is indicated that Registered staff:

Document correctly only those medications prepared and administered.

As such the licensee did not ensure that home's policy was complied with. [s. 8. (1) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not comply with LTCHA 2007, S.O., 2007, c.8, s.20(2) (b) and (d), in that the licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents clearly set out what constitutes abuse and neglect and contain an explanation of the duty under section 24 of the Act to make mandatory reports.

Policy # 2011/ANRAS entitled Abuse and Neglect of a Resident-Actual or Suspected dated on May 10, 2011 was provided to the Inspector #556 by the DOC upon request for the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the Abuse policy demonstrates that the policy does not clearly set out what constitutes verbal abuse and does not contain an explanation of the duty under section 24 of the Act, in that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident shall be immediately reported to the Director. [s. 20. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

During an interview with Resident #012, the Resident stated that RPN #S107 had been rude to him/her on more than one occasion although he/she had only reported one incident to the DOC. The Resident stated that a while ago a new Resident was brought in to the dining room and RPN #S107 was looking around to see where he could seat the new resident. Resident #012 offered the empty seat at his/her table, and RPN S#107 loudly stated "mind your own business". Resident #012 stated that he/she reported the incident to the DOC because he/she felt upset and embarrassed by the interaction.

On October 26, 2014, RPN #S107, wrote in the progress notes that Resident #012 was verbally inappropriate and loud in dining room to the RPN after he/she was told to mind his/her own business. Resident was trying to make suggestions on how people should be sitting in dining room. The RPN indicated that he tried to explain to him/her later but he/she was still upset and stated that it was not respectful to make such a statement to him/her.

Inspector #556 reviewed the home's internal documentation related to the incident and noted that on a specific date, the resident reported the incident to the DOC. The documentation stated that the resident was very upset because he/she was told by RPN #S107 to mind his/her own business. The internal documentation stated that Resident #012 felt insulted by the interaction, and felt the RPN was being disrespectful. The internal investigation documentation indicated that on a specific date, the DOC spoke with RPN #S107 regarding the incident and the RPN "admitted he was wrong and that he would apologize to the resident for his harsh remarks." The documentation stated that the incident was not reported to the MOHLTC and the DOC felt all parties involved appeared satisfied.

In an interview the DOC stated that Resident #012 reported the incident to her and that the resident felt offended, and was embarrassed and humiliated by the interaction. The DOC further stated that she does not doubt that something happened, but because she thought it was a one-time occurrence she did not feel it was necessary to report it to the MOHLTC. [s. 24. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Ontario Regulation 79/10, s. 48. (1) 2 states that every licensee of a long-term care home shall ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home.

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

The licensee has failed to ensure that wound assessments with respect to Resident #013 under the skin and wound care program were documented.

On March 2, 2015 during a staff interview RPN #S105 stated that Resident #013 had pressure ulcers stage II on his/her heels but was not able to found the relative information for the status and the treatment provided for the pressure ulcers.

On March 12, 2015 in an interview PSW #S123 stated that she has been away for a month but before she left Resident #013 had open pressure ulcers on both heels.

Later that day, in an interview RPN #S107 stated that weekly wound assessments are expected to be completed and documented when a resident has a pressure ulcer. RPN #S107 further stated that Resident #013’s pressure ulcers was now healed.

In an interview the DOC stated that when a resident is diagnosed with a pressure ulcer the registered staff are supposed to be completing a wound assessment using the tool on Point Click Care, and then weekly so that the progress of the wound can be monitored. The DOC further stated that all wounds, including those of Resident #013, are discussed at MDAC (Multi-disciplinary Assessment Committee) every Wednesday morning with the registered staff from all of the units. The DOC stated that Resident #013's wounds are now healed, and because the progress of Resident #013's wounds were discussed weekly at the MDAC meetings it seemed clear to her that the weekly assessments were being completed.

The DOC accessed Resident #013's health care record on Point Click Care with Inspector #556 and verified that weekly wound assessments were not documented for Resident #013. [s. 30. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 129 (1) (a) (ii) in that the licensee failed to ensure drugs are stored in an area or a medication cart that is secure and locked.

On March 03, 2015 two bottles of Ketoconazole 2% were observed in a Resident's private bathroom.

On March 04 and 05, 2015, two baskets containing prescribed creams were observed in the Nurses Nook located on the third Floor West unit. The door was left open and unattended at the time of both observations.

During an interview On March 3rd, with Resident #017, he/she indicated to inspector #592 that he/she was not aware of these two lotions being kept in his/her bathroom and that staff members are using these lotions for him/her.

During an interview on March 05, 2015 with PSW S#106, she told inspector #592 that Registered Staff are providing them prescribed creams to their assigned residents and when the creams need to be re-applied frequently, PSW are instructed to leave the prescribed creams in the Resident's room in order for them to have easy access to it.

During an interview on March 05, 2015 with RN S#105, she told inspector #592 that prescribed creams were to be kept locked. RN S#105 further indicated that prescribed creams are also being kept in the Nurse's Nook for the PSW"s to have accessibility. In addition she told inspector #592 that the Nurse's Nook door as a lock but usually staff leaves the door open and not locked.

Later that day, during an interview with the Director of Nursing, she told inspector #592 and inspector #161 that all prescribed medications are expected to be stored in an area that is locked. She further told both inspectors that if a prescribed medication was to be kept at bedside as a self-administration drug that she would expect to have the prescribed medication locked in the top drawer of the Resident's bed side table. [s. 129. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee as failed to ensure that the drug destruction and disposal policy provided that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

On March 04 and 05, 2015, while observing the home's medication management system, Inspector #592 observed the following:

In medication cart on the West unit of the third floor in the locked narcotic compartment, discontinued Lorazepam 1mg, 30 tablets for Resident #024

In medication cart on the East unit of the second floor in the locked narcotic compartment, discontinued Hydromorphone 1mg, 5 tablets for Resident #023

During an interview on March 04 with RN S#105, S#107, S#108 and S#109 they told inspector #592 that it was the home's regular practice to keep the discontinued controlled

substances that are to be destroyed with the controlled medications substances that are currently available for administration to resident in the double lock compartment in the medication cart. They told inspector #592 that Registered Staff identifies the discontinued controlled substances with an elastic band and kept them in the same compartment which contains two sections.

During an interview on March 06, 2015 with the DOC, she indicated to inspector #592, that the home current practice is to keep the discontinued controlled substances that are to be destroyed in the Medication cart in the double lock compartment which is separated in two sections with the controlled medications currently in use.

The DOC provided Inspector #592 with Policy Nursing 2013/NCDR dated on April 11, 2013. Upon review of the Procedure it is indicating:

That Discontinued medications are signed and dated by RN./R.P.N.
Narcotic Record remains with the medication in the narcotic cabinet in the med-cart until disposed of by pharmacist/Director of Nursing.

Although the DOC showed to inspector #592 that they have a new policy index number 04-07-20 dated on July 25, 2014 which indicates:

That discontinued narcotics and controlled substances are to be removed from the medication cart and the individual Narcotic and Controlled Substances Administration Record (07-10-60) signed and dated prior to being placed into the double lock centralized storage area within the facility.

The DOC stated that the home does not follow this new policy due to lack of storage and that the home still refer to the Policy Nursing 2013/NCDR. [s. 136. (2) 2.]

2. The licensee has failed to ensure that drugs must be destroyed by a team acting together and composed of, one member of the Registered Nursing Staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s.136(3)

For the purpose of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s.136(6)

On March 05, 2015 while observing the process of the home's medication management system, RN S#105 showed to inspector #592, a box located in the medication room in a cupboard under the sink which contained discontinued non-controlled substances. Non-controlled substances were observed in their original packages not altered or denatured. Rn S#105 told inspector #592 that once a medication is discontinued for a resident, Registered members are instructed to discard the discontinued medication in the box.

On March 06, 2015 inspector #592 and #161 accompanied by the DOC observed in the Medication storage room located on second floor, 4 full garbage bags containing discontinued tablets, injectable products, oral liquid, eye drops and topical creams which were not destroyed or denatured.

During an interview on March 06, 2015 following the observation of the Medication storage, the DOC indicated to both inspectors that the home's current practice is that Registered staff are instructed to remove the discontinued non-controlled substances from the medication cart and to discard them in a box located under the sink in each medication room.
She further indicated that when the box is full, the Registered staff are responsible to remove the non-controlled substances from the unit and to bring them to the Medication storage room. DOC told both inspectors that the current practice is to transfer the non-controlled substances in a garbage bag which they then transfer to a yellow bag put inside a box. The box is sealed with tape and identified for destruction in order for an offsite vendor to come to the home on a schedule cycle of four to six weeks to remove the non-controlled substances medication from the home for offsite incineration.
DOC further indicated that the home was waiting for the new process from the pharmacy for the destruction on site of the non-controlled substances but have not heard from them yet.

During an interview on March 06, 2015 with the Operation Consulted Pharmacist of the home with the presence of the DOC, he indicated to inspector #592 and inspector #161 that the home's current practice was to put non-controlled substances in a steri cycle container such as a white pail containing water to have the non-controlled substances altered and that the pail is then stored in a safe area until an offsite vendor comes to disposed of them.

During the interview, the DOC indicated to the Operation Consulted Pharmacist that the white pail was not received and that she was under the impression that the Pharmacy was doing the follow-up with the offsite vendor in order for the home to start the new

process.
She further indicated that the home was not destroying the non-controlled substances by team acting together as the home does not destroy the non-controlled substances on site. [s. 136. (3) (b)]

Issued on this 20th day of March, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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) :	MELANIE SARRAZIN (592), KATHLEEN SMID (161), PAULA MACDONALD (138), WENDY PATTERSON (556)
Inspection No. / No de l'inspection :	2015_381592_0004
Log No. / Registre no:	O-001648-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 19, 2015
Licensee / Titulaire de permis :	THE OTTAWA JEWISH HOME FOR THE AGED 10 Nadolny Sachs Private, Ottawa-Carleton, ON, K2A-4G7
LTC Home / Foyer de SLD :	HILLEL LODGE 10 NADOLNY SACHS PRIVATE, OTTAWA, ON, K2A-4G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	STEPHEN SCHNEIDERMAN

To THE OTTAWA JEWISH HOME FOR THE AGED, 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: 2014_199161_0026, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee will ensure that all staff who are involved in transferring Residents use safe transferring equipment and techniques when assisting Residents as detailed below:

Documented re-education which will include, but is not limited to the following components:

1. Complete return demonstration for their ability to ensure the measurement of a correctly fitting sling and the application of same,
2. Complete return demonstration for their ability to safely transfer a Resident as a lift operator on any/all different styles of transfer slings that they may be required to use in the course of their duties.

Grounds / Motifs :

1. Compliance Order pursuant to O.Reg 79/10, s.36 was first issued as a result of Critical Incident Inspection #2014_199161_0026 on November 25, 2014 with a compliance date of February 28, 2015.

The licensee failed to complete education for all staff who are involved in transferring Residents with a mechanical lift specifically:

1. Staff did not complete a return demonstration for their ability to ensure the measurement of a correctly fitting sling and the application of same,

2. Staff did not complete a return demonstration for their ability to safely transfer

a Resident as a lift operator on any/all different styles of transfer slings that they may be required to use in the course of their duties.

On March 5, 2015 a follow-up inspection was conducted in conjunction with the Resident Quality Inspection. The Director of Environmental Services/Coordinator of Quality Control (DESCQC) indicated to Inspector #161 that a Clinical Consultant from ArjoHuntLeigh Getinge Group (RHLGG) had been hired to provide the mechanical lift training to the staff and that the first in-service was held on December 15, 2014. Inspector #161 asked the DESCQC for the mechanical lift training in-service records for those staff who attended the education sessions provided by the Clinical Consultant from ArjoHuntLeigh Getinge Group (RHLGG). It is documented that 70 staff attended these in-service education sessions. The Director of Nursing and the DESCQC provided Inspector #161 with the “Nursing Department Employee Report” dated March 2, 2015. The number of nursing staff recorded on mechanical lift training in-service records was then compared to the “Nursing Department Employee Report.” It is noted that a total of 70 staff attended the mechanical lift training in-services, while the remaining 22 staff had not attended the mechanical lift training in-services as specified in the Compliance Order dated November 25, 2014. This was verified by the Director of Nursing and the Director of Environmental Services/Coordinator of Quality Control.

On March 5, 2015 Inspector #161 asked the DESCQC for the training content of the mechanical lift in-services provided by the Clinical Consultant RHLGG. The DESCQC provided a document titled “Hillel Lodge Training Content 2014/2015 ArjoHuntLeigh.” This document was reviewed by Inspector #161 and it was noted that there was no training content, as specified in the Compliance Order of November 25, 2014, that required staff to (1) complete return demonstration for their ability to ensure the measurement of a correctly fitting sling and the application of same nor, (2)complete return demonstration for their ability to safely transfer a Resident as a lift operator on any/all different styles of transfer slings that they may be required to use in the course of their duties. This was verified by the Director of Environmental Services/Coordinator of Quality Control. On March 6, 2015 during a telephone call, the Clinical Consultant from ArjoHuntLeigh Getinge Group informed Inspector #161 and the Director of Environmental Services/Coordinator of Quality Control that he had not required staff that he had in-serviced to date, to complete return demonstrations as stipulated in the Compliance Order dated November 25, 2014.

On March 5, 2015 discussion held with the Director of Nursing and the DESCQC in which they confirmed that not all required actions were completed as per the initial order.

(161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 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 19th day of March, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Melanie Sarrazin

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