Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: August 3, 2023	
Inspection Number: 2023-1220-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Six Nations of the Grand River	
Long Term Care Home and City: Iroquois Lodge Nursing Home, Ohsweken	
Lead Inspector Daria Trzos (561)	**Inspector Digital Signature**
Additional Inspector(s) Klarizze Rozal (740765)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 16, 19, 20, 21, 22, 23, 26, 27, 28, 2023 and July 5, 6, 2023

The following intake(s) were inspected:

- Intake: #00090197 - Proactive Compliance Inspection for Iroquois Lodge Nursing Home.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents’ and Family Councils

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (c)

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
The home's policy to promote zero tolerance of abuse and neglect was not posted in the home. The Administrator acknowledged the policy was not posted within the home and stated they would post the policy immediately. On the same day, the policy was posted on the main information bulletin board.

Sources: Observations and interview with the Administrator.

Date Remedy Implemented: June 16, 2023
[740765]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure that the home's current version of their visitor policy was posted in the home.

Rationale and Summary
The home's visitor policy was not posted in the home. The Administrator acknowledged the policy was not posted within the home and stated they would post the policy immediately. On the same day, the policy was posted on the main information bulletin board.

Sources: Observations and interview with the Administrator.

Date Remedy Implemented: June 16, 2023
[740765]

WRITTEN NOTIFICATION: Medication Management System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)

The licensee has failed to ensure that their medication management system provided safe medication management and optimal drug therapy outcomes for residents.

In accordance with O. Reg 246/22, s. 11 (1) (b) the licensee was required to ensure that the home's Medication Disposal Policy was fully implemented and complied with. Specifically, to ensure the destruction and disposal of medications.

Rationale and Summary
Vials of discontinued injectable medications and seven medication laxative containers with removed resident identification and prescription labels were observed stored in the medication room.

The home's Medication Disposal Policy, last reviewed March 2020, indicated that the home inspects all medication storage areas for the ongoing identification, destruction and disposal of expired drugs, drugs with illegible labels, and drugs in containers without legislated prescription labeling.

Registered Practical Nurse (RPN) acknowledged that all the illegible labelled medications and discontinued medications should have been disposed. They could not corroborate why the medications were stored and not disposed of.

Failure to provide safe medication management increased the risks for medication administration errors.

Sources: Observations, Medication Disposal Policy, 5.8, last reviewed March 2020, and interview with

staff.
[740765]

WRITTEN NOTIFICATION: Policy to minimize restraining of residents, etc.

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)

The licensee has failed to ensure the home's Least Restraint Policy was complied with.

Specifically, to ensure the completion of an initial restraint assessment and quarterly re-assessments.

Rationale and Summary
A resident was observed to have a device applied in their wheelchair. They were unable to remove it and needed staff assistance to apply it. The Director of Care (DOC) acknowledged the resident's use of the device was for safety and stated that an initial restraint assessment should have been completed. There were no records that an initial assessment or quarterly re-assessments were completed.

Failure to ensure the home's Least Restraint Policy was complied with posed a safety risk for the resident.

Sources: Resident's clinical records, Least Restraint Policy, RC-22-01-01, last reviewed March 2023; interview with the DOC.
[740765]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee has failed to seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

Rationale and Summary:
The binder with meeting minutes for the Resident and Family Councils did not contain information whether the satisfaction survey results were shared with both councils. The Family Council Chair and the

Secretary/Treasurer indicated that the results of the survey were not shared with them. The Social Worker (SW) and the Assistant to the Resident Council confirmed the results of the survey were not share with the councils.

Sources: Review of meeting minutes to the Resident and Family Council meetings; interview with the Family Council Chair and Secretary; interview with the recreation staff and SW.
[561]

WRITTEN NOTIFICATION: Duty to respond

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)

The licensee has failed to ensure that they responded in writing to the Resident Council of concerns or recommendations within 10 days of receiving them.

Rationale and Summary:
The licensee has not responded to concerns that were brought forward by the Resident Council during the last few meetings. The Administrator stated that they had the responses in their computer; however, they were not provided to the Council until the next meeting which was being held on every month.

Sources: Review of Resident Council meeting minutes; interview with the assistant to the Resident Council, and the Administrator.
[561]

WRITTEN NOTIFICATION: Doors in a home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents and those doors were kept locked when they were not being supervised by staff.

Rationale and Summary
On multiple days of observation during the inspection, doors leading to the home's linen rooms and

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

soiled linen/garbage rooms were observed accessible to residents. Keys were left in the lock cylinders of the doors with no staff supervision.

A RPN stated that the keys were to be secured and stored away after the use of the rooms and the keys should not have been left in the doors. They stated that the linen and garbage room doors should be kept locked at all times. The Administrator acknowledged that the rooms were non-residential areas and that leaving the keys in the doors made them accessible for residents.

Failure to ensure that doors leading to non-residential areas were kept locked posed a risk for resident safety.

Sources: Observations and interviews with staff.
[740765]

WRITTEN NOTIFICATION: Bed rails

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (b)

The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment.

Rationale and Summary
20 resident bed systems with bed rails were observed in the home which included 11 beds with upper quarter rails and nine beds with transfer rails.

The Environmental Service Manager (ESM) acknowledged that the bed systems in the home have not been evaluated within the last two years and the home has not maintained or updated their records for bed systems.

Failure to ensure bed entrapment testing were completed increased the risks for bed entrapments.

Sources: Observations, Bed Entrapment Testing Policy, RC-08-01-10, last reviewed January 2022, Health Canada Guidance Document, Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching reliability, and other Hazards, March 17, 2008, February 2020 bed system log, and interviews with ESM and DOC.
[740765]

WRITTEN NOTIFICATION: Air temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.

The licensee has failed to ensure that temperatures in at least two resident bedrooms in different parts of the home were measured and documented.

Rationale and Summary
The home's temperature logs for June 2023 indicated only one resident room temperature was measured and recorded per day. The DOC acknowledged that one resident room temperature was measured per day and they were unaware of the required number of resident rooms and specifications for temperature measurement and documentation as per their policies and legislative requirements.

Failure to measure and document temperatures in two resident rooms in different areas of the home, posed a risk to residents by not identifying temperatures that may require corrective action.

Sources: Temperature logs, Prevention of Heat Related Illnesses, RC-08-01-04, last updated, June 2023, interviews with DOC. [740765]

WRITTEN NOTIFICATION: Air temperature

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that the temperatures in the home were measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every night.

Rationale and Summary
The home's temperature logs for June 2023 indicated recordings for two documentation times per day, one for the morning and one for an evening or night shift. Multiple temperature documentations were missing from the maintenance and nursing temperature logs.

Both the Environmental Service Manager (ESM) and DOC acknowledged the missing air temperature documentations. They acknowledged they were unaware of the required times and rooms for temperature measurement and documentation as per legislative requirements.

Failure to measure and document temperatures in the home at the required times, increased resident risk by not identifying temperatures that may require corrective action.

Sources: Temperature logs, Prevention of Heat Related Illnesses, RC-08-01-04, last updated, June 2023, interviews with ESM and DOC.
[740765]

WRITTEN NOTIFICATION: Plan of care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.

The licensee has failed to ensure residents' plan of care were based on an interdisciplinary assessment regarding seasonal risk for heat related illness, including protective measures required to prevent or mitigate heat related illnesses.

Rationale and Summary
Three residents' clinical records indicated that no heat risk assessments were completed for the year 2023. A RPN stated they had not completed any heat risk assessments this year and that those were only completed when a resident had a heat related illness.

Failure to complete annual heat risk assessments for 2023 put residents at risk for heat related illnesses.

Sources: Residents' clinical records, Prevention of Heat Related Illnesses, RC-08-01-04, last updated June 2023, and interview with staff.
[740765]

WRITTEN NOTIFICATION: General Requirements

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to residents under the nursing and personal support services program including responses to interventions were documented.

Rationale and Summary
Three resident's Point of Care (POC) records indicated missing documentation for multiple activities of daily living (ADL), monitoring tasks, bladder, bowel, and nutritional care tasks on different dates and shifts in June 2023. Personal Support Workers (PSW) stated the expectations of documentation were to be conducted after completion of care. The DOC acknowledged that there were missing staff documentation.

Failure to document resident's responses to interventions may have resulted in care not being provided.

Sources: Resident's POC records and interviews with staff and DOC.
[740765]

WRITTEN NOTIFICATION: Food Temperatures

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure that the policy relating to nutritional care and dietary services and hydration programs was complied with.

Specifically, the home failed to ensure that the Temperatures of Food at Point of Service policy was complied with.

Rationale and Summary:
A lunch meal service was observed. The first course of the meal was a soup. The temperature of the soup was not taken as per kitchen staff. The point of service food temperature record did not contain the temperature taken of the soup. The kitchen staff were not aware that they needed to take the temperature of the soup.

Failing to take the temp of the soup may have increased the risk of the soup being too hot or too cold increasing the safety risk to residents.

Sources: Observation of meal service; review of point of service food temperature record; review of the home's policy "Temperature of Food at Point of Service" (last updated March 2019); interview with staff.
[561]

WRITTEN NOTIFICATION: Food Production

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)

The licensee has failed to ensure that the food production system, at a minimum, provided for, preparation of all menu items according to the planned menu.

Rationale and Summary:
The home had a planned menu in place for all recipes prepared inclusive of the different textures that were required by residents. The lunch meal service that was observed on two different days, had two options but only one option was provided for residents that required puree texture. Dietary staff and the cook indicated that the home provided only one option for residents requiring puree texture.

Failing to provide for all menu items according to the planned menu, may have had a negative impact on residents' rights, choices and dignity.

Sources: Observations of meal services; review of the planned menu in the home; interview with staff. [561]

WRITTEN NOTIFICATION: Cleaning Schedules

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (c)

The licensee has failed to ensure that the staff of the home complied with a cleaning schedule for the food production, servery and dishwashing areas.

Rationale and Summary:
During observations of the kitchen the following cleanliness issues were observed in the kitchen, servery and dishwashing areas:

-The floor between the fridge and freezer had debris and old piece of onion on the floor.
-The doors to the freezer were dirty and stained.
-Large amount of debris was present on the floor under the sink beside the dishwasher.
-Floors under sinks and cabinets and kitchen equipment were visibly dirty.
-Walls all around the kitchen, specifically closer to the bottom near the floor were visibly dirty and some

areas had dried yellow stains.
-The areas near the knobs on the oven were dirty with dried stains.
-The doors to the small oven on the counter were dirty.
-The counter on which the small oven was sitting had stains, and the shelves on the stand had dried accumulated stains.
-Beverage fridge had stains on the sliding doors.
-The floor fan near the dishwasher which was on, had large amounts of dust.
-A large amount of debris was present on the floor under the sink in the area next to the portable small oven.

The home had cleaning schedules in place; however were not being used. The deep clean of the kitchen has not been done since the pandemic had started.

Failing to keep the kitchen in a clean state, may have increased the risk for growth of bacteria, food contamination and spread of infections.

Sources: Observations of the kitchen; review of the policy Cleaning Schedule (last updated March 2019); interview with dietary staff, Food Services Manager (FSM), DOC and the Administrator.
[561]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (e)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) program was evaluated and updated at least annually in accordance with the standards and protocols issued by the Director.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 8.1, the licensee needed to ensure that the IPAC program was updated at least annually, and a written record was maintained for each evaluation including evaluation dates and time period, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Assistant Director of Care (ADOC) acknowledged that an annual IPAC program evaluation was not conducted for 2022. The home was unable to provide written records that an evaluation was

completed.

Failure to ensure the IPAC program was evaluated annually increased the risk for residents to receive care that was not as per emerging evidence and current best practices.

Sources: IPAC Standard for Long Term Care Homes, April 2022 and interview with ADOC.
[740765]

WRITTEN NOTIFICATION: Dealing with complaints

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that every written or verbal complaint made concerning the care of a resident or the operation of the home was investigated, resolved, and a response was provided within ten business days of the receipt.

Rationale and Summary
A resident reported they did not receive a follow-up response from the licensee regarding a complaint that was made.

The DOC stated they received resident’s complaint of care concerns and followed-up with them few weeks later. They acknowledged the delay in response and did not know they were required to provide a resolution and response within ten business days of receipt.

Failure to provide a response to resident’s complaint within ten business days, put the resident at risk for harm with a complaint that concerned resident.

Sources: Complaints and Customer Service Policy, RC-09-01-04, last reviewed April 2022; interviews with resident and DOC.
[740765]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)

The licensee has failed to ensure controlled substances were stored in a separate locked area within a locked medication cart.

Rationale and Summary
Four resident controlled substance pack cards were observed unsupervised and accessible on a counter in the medication room. A RPN acknowledged the four resident controlled substance pack cards observed on the medication room counter were to be stored and double locked in a separated locked bin within a locked medication cart.

Failure to ensure controlled substances were stored in a separated locked area in a locked medication cart increased the risks for potential harm and theft.

Sources: Observations, Medication of Insulin, Narcotics, and Controlled Drugs Policy, RC-16-01-13, last reviewed March 2023, and interviews with RPN and ADOC.
[740765]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee was composed of the homes medical director.

Rationale and Summary:
In an interview with the home’s Quality Improvement (QI) lead they had shared that the Medical Director was not part of the QI committee.

Sources: Interview with the QI lead; meeting minutes from the last QI meeting.
[561]

WRITTEN NOTIFICATION: CQI Initiative Report

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)

The licensee has failed to prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year.

Rationale and Summary:
In an interview with the CQI lead for the home, they had shared that the home did not prepare a report on the continuous quality improvement initiative for the 2023 fiscal year.

Sources: Review of the home's website; interview with the QI lead.
[561]

WRITTEN NOTIFICATION: Additional training- direct care staff

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received training on falls prevention and management in 2022.

Rationale and Summary
The home's training records for direct care staff on falls prevention and management indicated that the percentage (%) of completion for 2022 was 70%. The ADOC acknowledged that the training was not done for 100% of the direct care staff.

Failure to ensure that all staff received training led to a potential risk of staff being unfamiliar with the home's fall prevention and management program.

Sources: Surge training records for 2022 and interview with ADOC.
[740765]

WRITTEN NOTIFICATION: Website

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (b)

The licensee has failed to ensure that the approximate number of licensed beds at the home was posted on the home's website.

Rationale and Summary:
The home's website did not have the number of licensed beds posted which was confirmed by the Administrator.

Sources: Review of the home's website; interview with the Administrator.
[561]

WRITTEN NOTIFICATION: Website

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (c) (ii)

The licensee has failed to ensure that their website included the direct contact information for the home’s Administrator, including their telephone number and their email address they monitor regularly.

Rationale and Summary
The home’s website had no direct contact information for the home’s Administrator. The Administrator acknowledged their website required an update with the required contact information.

Sources: Review of the home’s website and interview with the Administrator.
[740765]

WRITTEN NOTIFICATION: Website

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (c) (iii)

The licensee has failed to ensure that their website included the direct contact information for the home’s Director of Nursing and Personal Care, including their telephone number and their email address they monitor regularly.

Rationale and Summary
The home’s website had no direct contact information for the DOC. The Administrator acknowledged their website required an update with the required contact information.

Sources: Review of the home’s website and interview with the Administrator.
[740765]

WRITTEN NOTIFICATION: Website

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (c) (iv)

The licensee has failed to ensure that their website included the direct contact information for the home's Infection Prevention and Control (IPAC) lead, including their telephone number and their email address they monitor regularly.

Rationale and Summary
The home's website had no direct contact information for the IPAC lead. The Administrator acknowledged their website required an update with the required contact information.

Sources: Review of the home's website and interview with the Administrator.
[740765]

WRITTEN NOTIFICATION: Website

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (d)

The licensee has failed to ensure that the Ministry's toll-free telephone number for making complaints about home was posted on the home's website.

Rationale and Summary:
The home's website did not have the Ministry's toll-free telephone number for making complaints about home posted which was confirmed by the Administrator.

Sources: Review of the home's website; interview with the Administrator.
[561]

WRITTEN NOTIFICATION: Website

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (f)

The licensee has failed to ensure that the current version of the emergency plans for the home were posted on the home's website.

Rationale and Summary:
The home's website did not have the current version of the emergency plans for the home posted which was confirmed by the Administrator.

Sources: Review of the home's website; interview with the Administrator.
[561]

WRITTEN NOTIFICATION: Website

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (g)

The licensee has failed to ensure that their website included the current version of the home's visitor policy.

Rationale and Summary
The home's website had no current version of the home's visitor policy. The Administrator acknowledged their website required an update with the current version of the home's visitor policy.

Sources: Review of the home's website and interview with the Administrator.
[740765]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Educate all PSW and Registered staff on the home's lift, specifically instructions for use as per the manufacturer's manual, including inspection of the safety belt, use, and maintenance.

2. Retain records of the education provided, including the names of the staff educated, date and time education was provided and by whom.

Grounds

The licensee has failed to ensure that staff use safe transferring and positioning devices when assisting residents.

Rationale and Summary
The safety belt on the home's lift in the tub room was observed not intact. The home's staff acknowledged the safety belt was broken and that they have been using the lift to transfer residents without the use of the safety belt. It was noted the safety belt has not been intact for two months. The ADOC immediately removed the lift from use. They stated that staff should have removed the lift from use and recorded the lift in the maintenance repair request log. There were no records of the lift in the maintenance repair log for May or June 2023. The staff could not corroborate why the lift was not sent for repair.

The home's manual for the lift indicated to use the safety belt at all times, to always inspect the safety belt for good condition before use, and that staff are to always attach the safety belt before the resident is seated in the lift.

Failure to ensure that staff used safe transferring and positioning devices increased residents' risks for injury and harm.

Sources: Observations, maintenance repair request logs, Lift Manual for Arjo Alenti Lift, 04.CD.05_9US.CA, June 2012, and interviews with staff and the ADOC.
[740765]

This order must be complied with by August 16, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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