Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 18, 2013	2013_217137_0025	L-000674-13	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CARE, LONDON
268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2

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

ST. JOSEPH'S HEALTH CARE, LONDON - MOUNT HOPE CENTRE FOR LONG TERM CARE - ST. MARY'S
21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6

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

MARIAN MACDONALD (137), JUNE OSBORN (105)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 4, 10, 11, 12, 25 and 27, 2013

During the course of the inspection, the inspector(s) spoke with Director, 2 Coordinators of Resident Services, 4 Registered Nurses, 2 Registered Practical Nurses, 1 RAI-MDS Coordinator, 1 Educator, 1 Registered Dietitian, 1 Administrative Assistant, 1 Coordinator of Food and Nutrition, 1 Customer Service Representative, 1 Food Service Technician and 2 Family Members.

During the course of the inspection, the inspector(s) observed resident and staff, toured resident home area, reviewed resident's clinical records, video clips, internal investigative reports and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Medication

Pain

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place:
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with, as evidenced by:

A review of the policy Pain Assessment and Management Of - reviewed March 2012, indicated the following:
Policy - # 2 - All residents are assessed quarterly for the presence of pain, as well as whenever there is a change in health status which has the potential to precipitate pain.
Procedure - # 6 - Residents are fully re-assessed every three months for the existence and quality of pain. If the MDS assessment indicates the presence of unresolved pain, the "Mount Hope Pain Assessment Tool" is used to gather specific information about the pain.

A review of an identified resident's progress notes revealed several documented entries where the resident expressed pain, including entries of increased pain, and required analgesics.
A Registered Nurse confirmed that pain assessments were not completed and the policy was not complied with. [s. 8. (1)]

2. A review of the policy, Skin Care & Assessment and Wound Management, Revised February 2011, Wound Identification and Care indicated:
22 - Wound care is provided by the RN/RPN on the shift the care is assigned to. The nurse providing the care assesses the wound weekly - the assessment findings and current treatment are documented. This assessment includes overall evaluation of the current plan of care, including dietary measures, etc., Documentation must occur more often if the wound is rapidly changing.

A review of the Weekly Wound/Skin Assessments revealed that the assessments are not consistently being conducted weekly, for an identified resident..
The Registered Practical Nurse confirmed that the expectation is that wound assessments be completed weekly and the home's policy was not complied with. [s. 8. (1)]

3. A review of the Administration Of Medications/Treatments" policy, revised July

2012, indicates the nurse responsible for medication/treatment administration must follow established procedures to ensure accuracy of medications administered, resident safety and efficiency.
It is the nurse's accountability to ensure that all residents take their medication when administered. This may mean direct supervision of the resident or returning to ensure medications have been taken.

The Coordinator of Resident Services confirmed that the Registered Practical Nurse did not supervise the medication administration for an identified resident and that the home's policy was not complied with. [s. 8. (1)]

4. A review of Policy: Lifts and Transfers - Date Revised: April 2013 indicates the following:
Policy Statement #3: "The accepted lift and transfer options used at Mount Hope (listed on page 3) are the approved methods of moving residents. Staff must adhere to these in their daily practice."
Policy statement #10. "Two caregivers must be present at all times for use of full-weight mechanical lifts(this includes sit-stand lifts, full weight mechanical lifts, and bathing lifts)."
Policy statement #15. "Staff who do not adhere to this policy will meet their Coordinator to discuss whether further training, communication or discipline is needed."

Procedure #35 in "Performing Lifts and Transfers"
"All staff carry out ALL MECHANICAL LIFTS (including bath lifts) USING TWO CARE PROVIDERS. Specifically, two caregivers must be present for the steps of the lifting process where resident safety is an issue e.g. the lifting and lowering stages of a full weight mechanical lift, or putting the resident on and off a bathing lift. If a second PCP is unavailable to assist, the second care provider may be an RN or RPN."

This policy was not followed as evidenced by:
Nine identified Primary Care Providers were observed independently transferring an identified resident, with a mechanical lift, on several different occasions.

The Coordinator of Resident Services confirmed the identity of the staff members involved and that the home's policy was not complied with. [s. 8. (1) (b)]

5. Policy:Cell Phone /Personal Technology Use at Mount Hope
Revised date: November 2011
Policy statement #1: "Mount Hope direct care staff may use personal cell phones and technological devices on personal time only, so that it does not interfere with resident care."
Procedure #1: "Staff may use cell phones on break or lunch time only- it is not acceptable to talk on, answer, message with, text with, check face book on or surf the internet on cell phones during work time e.g. cell phones and other technological devices are not to be taken into or used in resident rooms, corridors, etc"
Procedure #5: "Direct care staff should not only carry their cell phone or technological device on their person during work hours or during resident care- the focus should be on meeting resident' needs."

This policy was not complied with as evidenced by:

Three identified staff members were observed using personal cell phones during care provision and/or medication administration to an identified resident.
The Coordinator of Resident Services confirmed the identity of the staff members involved and that the home's policy was not complied with.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors was available to an identified resident as evidenced by:

Staff were observed removing and/or not providing call bell access to an identified resident.
The Coordinator of Resident Services confirmed the identity of the staff members involved and that the staff removed or did not provide call bell access to an identified resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: 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 has failed to ensure the policy to promote zero tolerance of abuse and neglect of residents complies with the requirements respecting training and retraining of all staff provided for in the regulations, [LTCHA, 2007, S.O, 2007, c.8, s.20(2)(g)], as evidenced by:

A review of Mount Hope Centre for Long Term Care Policy: Abuse and Neglect of Residents: Zero Tolerance - Revised Date: November 2012 indicates that the policy does not identify the training and retraining requirements for all staff, including, situations that may lead to abuse and neglect and how to avoid such situations as outlined in O Reg 79/10, s.96(e)(ii). [s. 20. (2)]

2. This policy also does not provide measures and strategies to prevent abuse and neglect [O Reg 79/10 s. 96(c)] [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the policy to promote zero tolerance of abuse and neglect of residents complies with the requirements respecting training and retraining of all staff provided for in the regulations [s.20(2)(g)], to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:
* has been assessed by a registered dietitian who is a member of the staff of the home, and
* had any changes made to the plan of care related to nutrition and hydration been implemented, as evidenced by:

A review of the progress notes for an identified resident, with impaired skin integrity, revealed that there was no initial referral made to the Registered Dietitian, as confirmed by the RD and the Referral to Dietitian section in Point Click Care. [s. 50. (2) (b) (iii)]

2. The Licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, as evidenced by:

A review of the Weekly Wound/Skin Assessments, for an identified resident, revealed that the assessments are not consistently being conducted.
A Registered Practical Nurse confirmed that the expectation is that wound/skin assessments be completed weekly and confirmed that the assessments have not been completed weekly. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds (iii)is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration been implemented, and (iv) is assessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the progress notes, for an identified resident, revealed there are several documented entries where the resident expressed pain, including entries of increased pain, and required analgesics.
There was no documented evidence that pain assessments were completed and this was confirmed by the Registered Nurse. [s. 52. (2)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as evidenced by:

Identified staff members were observed handling soiled/contaminated items, without hand washing or using hand sanitizer prior to providing direct care to an identified resident.

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: 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 failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident as evidenced by:

An incident was not immediately reported to the Director, as per the legislative requirements, and this was confirmed by the Home's Director, Long Term Care. [s. 24. (1)]

Issued on this 22nd day of October, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Marian C. Mac Donald

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIAN MACDONALD (137), JUNE OSBORN (105)
Inspection No. / No de l'inspection :	2013_217137_0025
Log No. / Registre no:	L-000674-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 18, 2013
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CARE, LONDON 268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2
LTC Home / Foyer de SLD :	ST. JOSEPH'S HEALTH CARE, LONDON - MOUNT HOPE CENTRE FOR LONG TERM CARE - ST. MARY'S 21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANN WOUTERS

To ST. JOSEPH'S HEALTH CARE, LONDON, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The Licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s.8(1)(a) & (b), to ensure that policies are implemented in accordance with applicable requirements under the Act and Regulations and that they are complied with.
Education must be provided to staff, including registered nursing staff, to ensure that all staff are aware of the policies.
The plan must identify how education will be provided to staff, who will be responsible for providing the education and how compliance will be monitored.

Please submit the plan in writing to Marian C. Mac Donald, Long-Term Care Homes Inspector-Nursing, Ministry of Health and Long-Term Care, Performance and Improvement Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON N6A 5R2, by email, at Marian.C.Macdonald@ontario.ca, by October 31, 2013.

Grounds / Motifs :

1. A Written Notification and Compliance Order were previously issued on October 24, 2011 and returned on February 21, 2012, related to policies not being complied with. A Written Notification and Voluntary Plan of Correction were previously issued related to staff using unsafe transferring techniques when assisting residents, on June 13 and July 5, 2012.

A review of the Administration Of Medications/Treatments" policy, revised July 2012, indicates the nurse responsible for medication/treatment administration must follow established procedures to ensure accuracy of medications administered, resident safety and efficiency.
It is the nurse's accountability to ensure that all residents take their medication when administered. This may mean direct supervision of the resident or returning to ensure medications have been taken.

The Coordinator of Resident Services confirmed that the Registered Practical Nurse did not supervise the medication administration for an identified resident and that the home's policy was not complied with.

(137)

2. A review of the policy, Skin Care & Assessment and Wound Management, Revised February 2011, Wound Identification and Care indicated:
22 - Wound care is provided by the RN/RPN on the shift the care is assigned to. The nurse providing the care assesses the wound weekly - the assessment findings and current treatment are documented. This assessment includes overall evaluation of the current plan of care, including dietary measures, etc., Documentation must occur more often if the wound is rapidly changing.
A review of the Weekly Wound/Skin Assessments revealed that the assessments are not consistently being conducted weekly, for an identified resident. The Registered Practical Nurse confirmed that the expectation is that wound assessments be completed weekly and the home's policy was not complied with.
(137)

3. A review of the policy Pain Assessment and Management Of - reviewed March 2012, indicated the following:
Policy - # 2 - All residents are assessed quarterly for the presence of pain, as well as whenever there is a change in health status which has the potential to precipitate pain.
Procedure - # 6 - Residents are fully re-assessed every three months for the existence and quality of pain. if the MDS assessment indicates the presence of unresolved pain, the "Mount Hope Pain Assessment Tool" is used to gather specific information about the pain.

A review of an identified resident's progress notes revealed several documented entries where the resident expressed pain, including entries of increased pain, and required analgesics.
A Registered Nurse confirmed that pain assessments were not completed and the policy was not complied with. (137)

4. A review of the Policy:Cell Phone /Personal Technology Use at Mount Hope - Revised date: November 2011 revealed the following:
Policy statement #1: "Mount Hope direct care staff may use personal cell phones and technological devices on personal time only, so that it does not interfere with resident care."
Procedure #1: "Staff may use cell phones on break or lunch time only- it is not acceptable to talk on, answer, message with, text with, check face book on or surf the internet on cell phones during work time e.g. cell phones and other technological devices are not to be taken into or used in resident rooms, corridors, etc"
Procedure #5: "Direct care staff should not only carry their cell phone or technological device on their person during work hours or during resident care- the focus should be on meeting resident' needs."

This policy was not followed as evidenced by :

Three identified staff members were observed using personal cell phones during care provision and/or medication administration.
The Coordinator of Resident Services confirmed the identity of the staff members involved and that the home's policy was not complied with.

(105)

5. A review of Policy: Lifts and Transfers - Date Revised: April 2013 indicates the following:
Policy Statement #3: "The accepted lift and transfer options used at Mount Hope are the approved methods of moving residents. (listed on page 3) Staff must adhere to these in their daily practice."
Policy statement #10. "Two caregivers must be present at all times for use of full -weight mechanical lifts(this includes sit-stand lifts, full weight mechanical lifts, and bathing lifts)."
Policy statement #15. "Staff who do not adhere to this policy will meet their

Coordinator to discuss whether further training, communication or discipline is needed."

Procedure #35 in "Performing Lifts and Transfers"
"All staff carry out ALL MECHANICAL LIFTS (including bath lifts) USING TWO CARE PROVIDERS. Specifically, two caregivers must be present for the steps of the lifting process where resident safety is an issue e.g. the lifting and lowering stages of a full weight mechanical lift, or putting the resident on and off a bathing lift. If a second PCP is unavailable to assist, the second care provider may be an RN or RPN."

This policy was not followed as evidenced by :

Nine Primary Care Providers were observed independently transferring an identified resident, with a mechanical lift, on several different occasions. The Coordinator of Resident Services confirmed the identity of the staff members involved and that the home's policy was not complied with.
(105)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 13, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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 18th day of October, 2013

Signature of Inspector / Signature de l'inspecteur : Marian C. Mac Donald

Name of Inspector / Nom de l'inspecteur : MARIAN MACDONALD

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