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 for each organized program required in the legislation there is a written description of the program which includes goals, objectives, relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes and to ensure that any action taken with respect to a resident under a program is documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. Residents are not bathed, at a minimum, twice a week by the by the method of his/her choice, and more frequently as determined by the resident's hygiene requirements.

a) During an interview with resident #701 it was identified that they have a requirement to bathe fully, on a daily basis. Interview with staff confirmed awareness of the bathing requirement, however due to resources is unable to meet this need. The plan of care identified that the resident was to have "a shower daily if staff is available". A review of the point of care documentation conducted on February 15, 2013 for the current month indicates that the resident was bathed on 5 occasions only. The resident is not bathed according to their identified hygiene requirements.

b.i) Resident #500 stated she preferred a tub bath, but could not recall the last time she was given one.
ii) Resident #429 stated she preferred a tub bath and stated staff were aware of her preference, but reported she never received one.
iii) Resident #426 stated she preferred a tub bath, but only receives a shower.
iv) Staff interviewed on two units confirmed that no residents on Lancaster unit receive a tub bath and reported they could not recall the last time the tub was used on Lakeside unit. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are bathed by the method of their choice at a minimum of twice a week or as determined by their hygiene requirements, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. 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. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the falls prevention and management program developed with the aim to reduce the incidence of falls and the risk of injury was fully implemented.

The DOC confirmed that the homes falls policies 09-01, 09-02 and 09-03 was the home's falls prevention and management program.
a) The home has a procedure titled "Falls", policy number 09-01.
i) Item #9 of this procedure indicates that the home "will implement a flagging system to clearly identify to all staff who the residents are that are at high risk for falls". Interview with front line and management staff confirmed that the home does not have a flagging system in place as per their procedure.
ii) Item #22 e. of this procedure indicates that for residents who remain in the home after a fall, staff are responsible for ongoing assessment of the resident for 72 hours. "At the end of the 72 hours post fall period the interdisciplinary team is to meet to review the assessment and observations completed and update the care plan accordingly with any required interventions". Interview with front line and management staff confirmed that the team does not meet at the end of the 72 hours post fall period to review the documentation and update the plan of care. Discussion with the DOC identified that when the "Falls Prevention and Restraint Reduction Committee" meets those who are frequent fallers are reviewed.

b) The home has a policy titled "Falls Prevention and Restraint Reduction Committee Terms of Reference" number 09-03. This document indicates that the committee meets on a monthly basis or more frequently as required. Interview with the DOC and ADOC confirmed that from approximately July 2012 until December 2012 the committee was not meeting on a monthly basis due to changes in staffing, random minutes requested were not available.

c) The home has a procedure titled "Falls", policy number 09-01.
i) Item #7 of this procedure indicates that "ongoing residents are to have a Fall Risk Assessment tool completed after the third fall in a quarter".
-Resident #492 had been identified as a high risk for falls. The resident's Minimum Data Set assessment was completed on August 5, 2012. The resident sustained six falls during the identified quarter. A Fall Risk Assessment was not completed after the third fall as per the procedure.
-Resident #472 had sustained 3 falls in one quarter from August 2012-November 2012 however; there was no fall risk assessment tool completed for the third fall.

ii) Item #18 of this procedure indicates that "a Post Fall Assessment is to be completed after a resident falls". The DOC confirmed that the Post Fall Assessment tool to be completed is the "PLS - Post Fall Assessment".
-Resident #492 sustained eight falls with no Post Fall Assessments recorded.
-Resident #459 sustained two falls. The resident did not have a PLS Post Falls Assessment completed following these incidents.
-Resident #472 sustained a fall however there was no post fall assessment completed for this incident.
iii) Item #22 of this procedure indicates that "if the resident remains in the home after a fall, Registered Staff are responsible for ongoing assessment of the resident for 72 hours after the fall"
-Resident #472 sustained a fall, however there was only ongoing assessment of the resident completed and documented for 24 hours post fall. [s. 48. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the falls prevention and management program is fully implemented, to be implemented voluntarily.

WN #9: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 did not ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

a) Resident #395 was admitted to the hospital and returned to the home four days later. The resident was transferred and admitted to hospital a second time returning to the home seven days later. According to the clinical record and staff interviewed, a head to toe skin assessment was not completed upon either return from hospital.
b) Resident #401 returned from hospital however, there was no head to toe skin assessment completed and documented when they returned to the home. The RN confirmed that a head to toe was not completed. [s. 50. (2) (a) (ii)]

2. The resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, did not receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

a) Staff identified two open areas on resident #401 on January 25, 2013. The wound care nurse confirmed that a dressing was applied to the open areas and a reddened area and registered staff were to change the dressing every 5 days or as needed. The wound care nurse returned February 5, 2013, and discovered that the treatment order had not been processed and staff were not aware to change the dressing. The TAR confirmed there was no treatment provided every 5 days as indicated. The wound care nurse confirmed that the resident's reddened area was now open.

b) A multidisciplinary note dated October 2, 2012 identified that resident #401 continued to have a stage III ulcer with treatment ordered every other day and as required. Documentation indicated that the treatment had been discontinued October 3, 2012 while the ulcer was still present. The resident did not receive treatment from October 2 to October 9, 2012, when the order was reinstated. [s. 50. (2) (b) (ii)]

3. The licensee did not ensure that the resident exhibiting altered skin integrity, including, skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Resident #387 was identified with a stage IV ulcer on admission in 2012. According to documentation and staff interviewed, the resident's wound was not assessed for approximately 2 weeks in 2012. On November 18, 2012, the resident

was identified with a stage II skin tear, measuring 3.5 cm long and 2cm wide. This affected area was not reassessed after this date. This information was confirmed by staff.
b) Resident #401 had stage II ulcers; there was no wound assessment completed for the weeks of July 17, 2012 and September 4, 2012. One area was deemed stage III September 18, 2012 however; there was no wound assessment completed for the weeks of September 25, 2012 and October 23, 2012. A skin assessment completed October 30, 2012 indicated the resident continued to have an open area however; there were no further assessments completed. Staff confirmed that weekly wound assessments were not consistently completed. [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 compliance with O. Reg 79/10 s. 50(2), to be implemented voluntarily.

WN #10: 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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a person who had 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 risk of harm to the resident, immediately reported the suspicion and the information for which it was based to the Director.

i) In 2012, staff responded to resident #459 screaming and found resident #504 standing over them holding their hands while trying to kiss them. The record indicated resident #504 had tried kissing resident #459 twice that day and that the resident did not want to be kissed, the resident had screamed, "no".
ii) In 2012, staff reported witnessing resident #504 touching the breast of resident #459. Staff intervened to separate the residents.
Discussion held with the DOC, who was the ADOC at the time of the incidents, confirmed that neither incident was reported to the Director. There was no record located of the incidents being reported to the Director. [s. 24. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. A plan of care was not based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's dental and oral status, including oral hygiene.

a) Resident #472 had some loss of natural teeth and refused to wear dentures. A resident assessment protocol for dental care dated November 28, 2012 indicated the resident was unable to brush own teeth and becomes very agitated. Staff confirmed that the resident was not capable of brushing their own teeth and frequently refused assistance becoming very agitated and striking out at times when staff attempt to assist the resident however; registered staff confirmed that there was no care plan for oral hygiene. [s. 26. (3) 12.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the policy was complied with.

a) The home's Restraints-Physical/Mechanical policy #08-18 indicated that staff complete a pre-restraint assessment form prior to the use of the restraint with the exception of the emergency use of restraint in which case it would be completed within 12 hours of application.
Resident #472 had a restraint put in place in the fall of 2012 however, staff confirmed that the use of the restraint was not an emergency situation and there was no pre-restraint assessment form completed prior to the use. [s. 29. (1) (b)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

i) Resident #472 had a physician's order and consent for a specified device however; throughout the inspection the resident had a different device applied and staff confirmed use of the second device and and not the device ordered and consented to. The resident's plan of care indicated the use the device which was ordered by the physician.

WN #14: 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, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that each resident was offered a minimum of a snack in the afternoon and evening.

a) A PSW entered resident #600's room and provided a tea however the resident was not offered a snack during the afternoon nourishment pass on February 14, 2013. The resident stated that they have own snacks however did not have any left at this time and verbalized desire for a snack. [s. 71. (3) (c)]

2. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.

a) Resident #601 was not offered the planned menu items indicated on their individualized menu during the lunch meal on February 15, 2013. The planned menu items for the individualized menu were prepared however; it was not offered to the resident.
b) Resident #600 was not offered the planned menu items indicated on their individualized menu during the lunch meal on February 15, 2013. Staff confirmed that the planned menu items for the individualized menu were not prepared and available to offer the resident during the lunch meal. [s. 71. (4)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the home had a dining and snack service that included, at a minimum, providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

a) Resident #602 had a mug of soup placed in front of him when the inspector entered the dining room on February 5, 2013 at 12:30 hours. The resident's tablemate made several attempts to take the resident's soup. At least twice, staff approached the tablemate to discourage him from taking the resident's soup however; staff did not make any attempts to encourage him to consume his soup. At 12:48 hours the tablemate consumed the resident's soup. [s. 73. (1) 9.]

2. The licensee did not ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide assistance.

a) On February 5, 2013, during the lunch meal service resident #505 and #506 were served their soup at 12:30 hours and not provided assistance with eating until 12:40 hours. Staff interviewed confirmed that both residents require total assistance with eating.
b) On February 5, 2013 a soup was portioned and placed on the window sill beside the resident when the inspector entered the dining room at 12:30. The resident did not receive assistance to eat the soup until 12:50 when a staff member fed the resident in the dining room. [s. 73. (2) (b)]

WN #16: 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 of a long term care home shall ensure that drugs are stored in an area or medication cart that was secure and locked.

On February 7, 2013 at 13:00 the medication cart was unlocked outside the Montebello dining room. The RPN was feeding a resident inside the dining room with her back to the dining room entrance. The RPN was unaware the medication cart was unlocked and confirmed that the medication cart was to be locked. [s. 129. (1) (a) (ii)].

WN #17: 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. Not all staff participate in the implementation of the infection prevention and control program.

a) The home has a procedure for the "Changing/Cleaning of Leg and Drainage Bags for Indwelling Catheters", policy 07-10. This procedure directs staff to empty and then wash the collection bag with a solution of detergent and water before using a vinegar/water solution for soaking, then to drain the bag fully and hanging it to dry. On February 6, 2013, at 11:36 hours a catheter bag, containing a small amount amber coloured liquid, was noted to be hanging on the towel bar in a shared washroom. Staff did not participate in the program by failing to empty and clean the bag as per the home's procedure.

b) The home has a procedure regarding the "Cleaning of Resident Care Equipment" policy number 06-02. This procedure directs care staff to clean nail clippers - single resident use, after each use with alcohol. During a tour of the home, on February 5, 2013, it was observed in two spa areas that nail clippers were stored in the nail caddy's prior to cleaning as a number a clippers and storage compartments were observed to have nail clippings. [s. 229. (4)]

Issued on this 22nd day of February, 2013

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

Original licensee report signed by inspection team

Ontario

Ministry of Health and Long-Term Care

Ministère 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) :	LISA VINK (168), GILLIAN TRACEY (130), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2013_188168_0010
Log No. / Registre no:	H-000072-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 22, 2013
Licensee / Titulaire de permis :	HENLEY HOUSE LIMITED 200 RONSON DRIVE, SUITE 305, TORONTO, ON, M9W-5Z9
LTC Home / Foyer de SLD :	THE HENLEY HOUSE 20 Ernest Street, St. Catharines, ON, L2N-7T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOHN BERGIN

To HENLEY HOUSE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère 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

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. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the safe use of physical devices, used for the restraining of residents.
This plan shall include, but not be limited to:
a) education related to the manufacturer's instructions for the use of the device
b) education regarding the home's policy and procedure related to physical restraints and the role/responsibilities of staff
c) auditing and risk management activities
The plan shall be submitted electronically to Inspector Lisa Vink on or before March 8, 2013 at Lisa.Vink@ontario.ca.

Grounds / Motifs :

1. The licensee of the long-term care home did not ensure that all requirements are met with the respect to the restraining of a resident by a physical device under section 31 or section 36 of the act:
1) Staff apply the device in accordance with any manufacturer's instructions.

a) On February 5 and 11, 2013, residents #443 and #700 were noted to be wearing restraints which were loose fitting and not snug to their abdomens. The physical devices were not applied in accordance with the manufacturer's instructions. Interviews with staff on February 11, 2013, confirmed that both of the devices were restraints and could not be removed by the residents. Staff were aware, based on education that they had received, that the specified devices used to restrain a resident should be tightened to the distance of approximately 2 finger widths. The devices observed on February 5 and 11, 2013, were approximately 4-5 inches from the residents abdomen, which is not consistent with manufacturer's instructions.
b) Resident #603 was observed on February 13, 2013 at 15:25 hours with a loose device. The resident was observed pulling the device out until it reached the end. A PSW tightened the device however; stated that the resident pulls the device loose.
c) Resident #472 was observed on February 13, 2013 at 14:30 hours to have a device applied loosely. The PSW confirmed that the device was applied loose. On February 14, 2013 at 10:30 hours the resident was observed to have the device applied loosely for a second time. The PSW confirmed that the device was applied with a space that was greater than two fingers between the resident's pelvic crest and the device.

(168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 05, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of February, 2013

Signature of Inspector / Signature de l'inspecteur : L Vink

Name of Inspector / Nom de l'inspecteur : LISA VINK

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