Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

Hamilton Service Area Office
119 King Street West 11th Floor
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Bureau régional de services de Hamilton
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 14, 2016 | 2016_247508_0009 | 011215-15 | Complaint |

### Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

MILLENNIUM TRAIL MANOR
6861 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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

ROSEANNE WESTERN (508), KERRY ABBOTT (631)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): May 26, 27, 30, 31, June 1, 2016.**

**During the course of this inspection, the inspector toured the facility, reviewed clinical records, relevant policies and procedures, observed the provision of care, observed meal service, interviewed staff, residents and family members**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, registered staff, personal support workers (PSWs), Food Service and Nutrition Manager, dietary staff, residents and family members.**

**The following Inspection Protocols were used during this inspection:**
**Hospitalization and Change in Condition**
**Pain**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001 had cognitive impairment and had appointed a SDM for all health care decisions.

On an identified date in 2016, the resident had a change in condition and became symptomatic of an infection. The resident was treated at the home for these symptoms for several days. Staff notified the physician of the resident's condition.

The physician ordered a specimen to be obtained and a medication was ordered to be started once they received confirmation of an infection. Staff were unsuccessful in obtaining the specimen and the following day staff notified the physician. The physician gave the order to initiate the medication and staff administered the medication later that morning. Resident #001 expired later that evening.

During an interview with the resident's SDM, the SDM indicated that although they visited the resident daily, staff had not discussed with them whether they wanted resident #001 to be treated at the home or to be transferred to hospital.

A review of the resident's clinical record indicated that there were no documented

discussions during this time with the resident's SDM. Staff #103 and staff #108 verified this information during interviews on May 31, 2016.

It was confirmed by staff and by the resident's clinical record that the resident's SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care when the resident had a change in condition. [s. 6. (5)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of the clinical health record for resident #001 indicated that the resident became symptomatic of an infection on an identified date in 2016. Registered staff #103 documented that she assessed resident #001 when it was observed that the resident was symptomatic of an infection. Medication was administered to manage the resident's symptoms.

Staff regularly administered the medication to resident #001 to manage the resident's symptoms and on an identified date in 2016, staff #109 notified the physician of the resident's ongoing symptoms. The physician ordered a specimen to be obtained to rule out a specific type of infection. The resident was started on an additional medication the following day; however, the resident expired later that day.

Over a four day period, the resident's health condition declined. Front line staff caring for resident #001 referred to the resident's care plan for direction in providing care to residents; however, during this time the care plan had not been revised when the resident became symptomatic of an infection.

It was confirmed by the RAI Co-ordinator and by review of the resident's plan of care that the plan had not been reviewed or revised when the resident's care needs changed. [s. 6. (10) (b)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #003 had a history of pain in several areas of their body. The resident received regularly scheduled analgesics to manage this pain. On an identified date in 2016,

resident #003 verbalized that the resident was experiencing pain in the leg and foot.

The resident continued to complain of severe pain in the leg especially during times when care was being provided to the resident and when the resident was being transferred.

Pain assessments completed during this time indicated that the resident's pain was not being managed with the current interventions and an increase in the resident's pain medication was ordered by the physician.

The resident continued to complain of pain after the resident's medication had been increased and the resident requested that an x-ray be obtained. The x-ray confirmed that the resident had an injury.

A review of the resident's current plan of care indicated under the pain focus that the resident had pain related to immobility and interventions identified that the resident's pain was in the lower back.

The plan of care to address the resident's pain had not been updated to include the resident's pain related to the injury.

It was confirmed during an interview with the Resident Assessment Instrument (RAI) Co-ordinator on May 30, 2016, that the resident's plan of care related to pain had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident's substitute decision-maker (SDM) is given the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy titled Pain Management, #CN-P-09, dated January, 2016, indicated the following:

1.The interdisciplinary team will assess residents for pain considering factors such as age and level of cognition on admission, re-admission, quarterly or with a change in condition that impacts pain or causes pain using Resident Assessment Instrument – Minimum Data Set (RAI-MDS) tool.

2.The health care team has a responsibility to identify pain as an issue that requires management and treatment. All residents are observed for indicators for pain daily by Personal Support Workers (PSW) and or Registered staff. If a resident had indicators of pain then an assessment is done. Some indicators of pain includes but is not limited to:

a. Distress related to behaviours or facial grimace
b. Resident/family/staff/volunteer indicate pain is present
c. Significant increase in use of PRN medication

Resident #003 had been identified as having pain in several areas of their body and was taking regularly scheduled narcotics to manage this pain. On an identified date in 2016, the physician increased this medication to improve the management of the resident's pain.

A review of the resident's clinical record indicated that the resident verbalized to the

physician that the pain was in the resident's leg and foot. On an identified date in 2016, the resident complained of pain throughout the day and was resistive to care. The following day, the resident complained of pain in their leg and groin area when care was being provided and while being transferred.

The physician again increased the dosage of the resident's narcotic for better pain management. Three days later, the physician ordered a PRN (when necessary ) narcotic for breakthrough pain. The resident continued to complain of pain and indicated that the pain was not being managed and requested an x-ray. Three days later, it was confirmed through an x-ray report that the resident had an injury.

The following day, the resident spoke with the physician and decided not to have surgical intervention; however, indicated that the resident was still in pain. The physician increased the dosage again of the resident's regularly scheduled narcotic.

On an identified date in 2016, the resident reported to staff #103 that the resident had constant, dull pain and described the level of pain as seven out of ten. The staff administered medication to relieve the resident's pain. The resident continued to require breakthrough medication to manage the pain. Over a five month period, the resident had episodes of uncontrolled pain and had a change in condition that impacted pain or caused pain; however, staff did not consistently assess the resident's pain as directed in the home's Pain Management policy.

It was confirmed through documentation and during an interview with the RAI-Co-ordinator on May 30, 2016, that staff had not complied with the Pain Management policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

Resident #001 was cognitively impaired and had a change in their condition on an identified date in 2016. The resident had vomited during the night on an identified date in 2016.

The following day, the resident was observed to be symptomatic of an infection and when staff #103 assessed the resident it was identified that the resident had a fever. Staff #103 indicated that the resident was not able to explain what was wrong; however, administered medication to treat the resident's fever.

The following morning, the resident vomited again and was febrile. Staff reported the resident's condition to the Registered Nurse (RN). The RN assessed the resident and indicated that the resident was moaning but unable to verbalize discomfort. The resident was not assessed for pain.

Resident #001 continued to have an elevated temperature and staff administered medication to the resident for comfort. The resident continued to receive medication to treat their fever and nausea.

The resident continued to have a fever, was awake and moaning while holding their abdominal area; however, the resident was not assessed for pain. Later that morning, the resident continued to be febrile and was tachycardic (heart rate greater than 100 beats per minute).

The resident continued to decline and on an identified date in 2016, medication therapy was initiated due to a suspected infection. The resident was given medication for comfort and required treatment for low blood oxygen levels. The resident expired later that evening.

The resident exhibited changes in their condition and was not able to communicate symptoms including pain or discomfort. Over this four day period, the resident was not reassessed for pain as directed in the home's Pain Management policy.

It was confirmed through documentation and during an interview with the RAI-Co-ordinator on May 30, 2016, that staff did not comply with the Pain Management policy. [s. 8. (1) (b)]

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy titled, Documentation, #CN-D-17, dated April, 2011, indicated the following:

1.Personal Support Workers (PSW) must document intake of food and fluid for all meals and snacks on Nutritional Flow Chart.
2.It is important to complete these accurately and in detail to ensure accurate accounting of resident intake.

A review of resident #001's Nutritional Flow Chart indicated that over a seven day period when the resident had a change in their condition, there were 11 omissions related to the resident's intake for food and fluids. Staff interviewed on May 27, 2016, indicated that if a resident refused food or fluid or had no intake for any reason, this must be recorded on the flow chart and not left blank.

The policy also indicated that under the rules of documentation, that all entries are dated, timed and signed with name and status of person who documented.
On two specific dates, PSW staff who documented on the resident's Nutritional Flow Chart did not sign their name or their initials as required.

It was confirmed through documentation and by staff on May 27, 2016, that the home's Documentation policy was not complied with. [s. 8. (1) (b)]

4. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

Resident #001 became symptomatic of an infection in 2016, and had ongoing symptoms of an infection until the resident expired.
A review of the Medical Certificate of Death completed by the physician for resident #001, identified the resident's cause of death.

A review of the resident's clinical record indicated that staff #107 spoke with the resident's SDM after the resident expired and documented in the clinical record that the resident's SDM was upset about the resident's cause of death.

Staff #107 completed and submitted the Institutional Patient Death Record to notify the Coroner's office of the resident's death. Questions on the form which required a yes or no response included the question, 'has the family or any of the care providers raised concerns about the care provided to the deceased?'
Staff #107 indicated 'no' on the form after the resident's SDM had indicated to staff #107 that they were upset about the cause of death.

During an interview with the resident's SDM on June 1, 2016, the resident's SDM stated that they were upset when the staff informed them of the resident's cause of death as the SDM felt the resident could have been transferred and treated in the hospital and may have survived.

A review of the home's Documentation policy, item #2, under the rules of documentation directed staff to ensure that their entries are accurate and true.

It was confirmed through documentation and interviews with the SDM and staff #107 that the documentation policy was not complied with. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Resident #003 had a history of pain in several areas of their body. The resident received regularly scheduled analgesics to manage this pain. On an identified date in 2016, resident #003 verbalized an increase in the pain in other areas of their body and the physician increased the resident's medication.

A review of the resident's clinical record indicated that the resident again verbalized to the physician that the pain was in their leg and foot. The resident continued to complain

of pain and was resistive to care. On an identified date in 2016, the resident complained of pain in their leg and groin area when care was being provided and while being transferred.

The physician again increased the dosage of the resident's narcotic for better pain management and then three days later the physician ordered a PRN (when necessary) narcotic for breakthrough pain.

The resident continued to complain of pain and indicated that the pain was not being managed and requested an x-ray. Three days later, it was confirmed through an x-ray report that the resident had an injury.

The following day, the resident spoke with the physician and decided not to have surgical intervention; however, indicated that the resident was still experiencing pain. The physician increased the dosage again of the resident's regularly scheduled narcotic.

On an identified date in 2016, the resident reported to staff that the resident had constant, dull pain and described the level of pain as seven out of ten. The staff administered medication to relieve the resident's pain; however, the resident continued to require breakthrough medication to manage the pain.

Over a five month period, the resident had episodes of uncontrolled pain. Although pain assessments had been conducted using a clinically appropriate assessment instrument and the pain medication had been adjusted, the resident was not consistently assessed using a clinically appropriate instrument when clinically indicated.

It was confirmed through documentation and by the RAI Coordinator during an interview on May 30, 2016, that when the resident's pain was not relieved by initial interventions, the resident was reassessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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

Resident #001 was cognitively impaired and had a change in their condition on an identified date in 2016. The resident had vomited during the night on an identified date in 2016.

The following day, the resident was observed to be symptomatic of an infection and when staff #103 assessed the resident it was identified that the resident had a fever. Staff #103 indicated that the resident was not able to explain what was wrong; however, administered medication to treat the resident's fever.

The following morning, the resident vomited again and was febrile. Staff reported the resident's condition to the Registered Nurse (RN). The RN assessed the resident and indicated that the resident was moaning but unable to verbalize discomfort. The resident was not assessed for pain.

Resident #001 continued to have an elevated temperature and staff administered medication to the resident for comfort. The resident continued to receive medication to treat their fever and nausea.

The resident continued to have a fever, was awake and moaning while holding their abdominal area; however, the resident was not assessed for pain. Later that morning, the resident continued to be febrile and was tachycardic (heart rate greater than 100 beats per minute).

The resident continued to decline and on an identified date in 2016, medication therapy was initiated due to a suspected infection. The resident was given medication for comfort and required treatment for low blood oxygen levels. The resident expired later that evening.

The resident exhibited changes in their condition and was not able to communicate symptoms including pain or discomfort. Over this four day period, the resident was not reassessed for pain using a clinically appropriate assessment instrument specifically designed for this purpose, when indicated.

This information was confirmed through documentation and by an interview with the RAI Co-ordinator on May 30, 2016. [s. 52. (2)]

***Additional Required Actions:***

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

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**Issued on this 15th day of July, 2016**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ROSEANNE WESTERN (508), KERRY ABBOTT (631) |
| **Inspection No. / No de l'inspection :** | 2016_247508_0009 |
| **Log No. / Registre no:** | 011215-15 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jul 14, 2016 |
| **Licensee / Titulaire de permis :** | 955464 ONTARIO LIMITED<br>3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6 |
| **LTC Home / Foyer de SLD :** | MILLENNIUM TRAIL MANOR<br>6861 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Stephen Moran |

To 955464 ONTARIO LIMITED, 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)

**Linked to Existing Order / Lien vers ordre existant:** 2015_323130_0008, CO #001;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that all residents that have a change in their condition have their plans of care reviewed and revised when the resident's care needs change.

The plan is to include, but is not limited to the following:

1. The implementation of a process that staff must follow when it has been identified that a resident's care needs have changed, specifically residents who develop an infection or a change in their pain management.
2. The implementation of an on-going auditing system to ensure on-going compliance in relation to the review and revision of resident's plans when their care needs change.

The plan is to be submitted on or before August 31, 2016, to Roseanne Western via email at Roseanne.Western@ontario.ca

Previously issued as non-compliant [6.(10) b] on July 30, 2015, as a compliance order.

The Order is made based upon the application of the factors of severity (1), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect to minimal harm of the resident, the pattern of two out of three plans identified as non-compliant and the licensee's history of on-going non compliance previously issued as a compliance order.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed, in relation to the following:

**Grounds / Motifs :**

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #003 had a history of pain in several areas of their body. The resident received regularly scheduled analgesics to manage this pain. On an identified date in 2016, resident #003 verbalized that the resident was experiencing pain in the leg and foot.

The resident continued to complain of severe pain in the leg especially during times when care was being provided to the resident and when the resident was being transferred.

Pain assessments completed during this time indicated that the resident's pain was not being managed with the current interventions and an increase in the resident's pain medication was ordered by the physician.

The resident continued to complain of pain after the resident's medication had been increased and the resident requested that an x-ray be obtained. The x-ray confirmed that the resident had an injury.

A review of the resident's current plan of care indicated under the pain focus that the resident had pain related to immobility and interventions identified that the resident's pain was in the lower back.

The plan of care to address the resident's pain had not been updated to include the resident's pain related to the injury.

It was confirmed during an interview with the Resident Assessment Instrument (RAI) Co-ordinator on May 30, 2016, that the resident's plan of care related to pain had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

(508)

2. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of the clinical health record for resident #001 indicated that the resident became symptomatic of an infection on an identified date in 2016. Registered staff #103 documented that she assessed resident #001 when it was observed that the resident was symptomatic of an infection. Medication was administered to manage the resident's symptoms.

Staff regularly administered the medication to resident #001 to manage the resident's symptoms and on an identified date in 2016, staff #109 notified the physician of the resident's ongoing symptoms. The physician ordered a

specimen to be obtained to rule out a specific type of infection. The resident was started on an additional medication the following day; however, the resident expired later that day.

Over a four day period, the resident's health condition declined. Front line staff caring for resident #001 referred to the resident's care plan for direction in providing care to residents; however, during this time the care plan had not been revised when the resident became symptomatic of an infection.

It was confirmed by the RAI Co-ordinator and by review of the resident's plan of care that the plan had not been reviewed or revised when the resident's care needs changed. [s. 6. (10) (b)]
(508)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 2016

## 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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 14th day of July, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Roseanne Western

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