Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 13, 14, 17, 18, 19, 20, 21, 24, 25, 27, 2012	2012_061129_0011	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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with residents, registered and unregulated nursing staff, Registered Dietitian, Physician, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) observed residents and reviewed documents including clinical records and the homes policies and procedures in relation log # H-001732-12.

The following Inspection Protocols were used during this inspection:

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care
Specifically failed to comply with the following subsections:

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;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were assessed by a registered dietitian who is a member of the staff of the home, in relation to the following: [50(2)(b)(iii)]
Clinical records and documentation provided by the home indicated that resident #1, #2 and #3 had skin wounds that required treatment. The Registered Dietitian confirmed that referrals for residents #1, #2 and #3 were not received and these residents were not assessed from a nutritional perspective related to wound healing.
2. The licensee did not ensure that a resident exhibiting altered skin integrity, including pressure ulcers received immediate treatment and interventions to promote healing, with respect to the following: [50(2)(b)(ii)]
Resident # 1 did not receive immediate treatment and interventions to promote healing of a skin ulcer.
-Staff documented in the Wound Assessment Tool that necrosis was identified, but took no action to address the identified tissue death. Staff and the clinical record confirmed that this information was not provided to the resident's physician and that a referral to a wound specialist was not initiated.
- Staff documented in the clinical record that the wound was worsening, the open area is larger, there were blackened areas around the wound and there was a foul odor present. Staff and the clinical record also confirmed that action to address the worsening condition of this wound and particularly the identification of tissue death, was not taken for 6 days when a Registered Nurse Extended Class (RNEC) assessed the resident and immediately ordered the resident sent to hospital for further assessment and treatment of this wound.
- The resident returned to the home following treatment in hospital for this wound which included an surgical procedure.

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 by ensuring that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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, to be implemented voluntarily.

WN #2: 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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee did not ensure that there is a written plan of care for each resident that sets out clear directions for staff and others who provided direct care to the resident, in relation to the following: [6(1)(c)]

Registered and unregulated staff confirmed that the documents used by direct care staff to identify care required by residents were both the care plan and the kardex. Following a review of these and other clinical documents staff confirmed that care directions were not clear and there is conflicting information between clinical documents with respect to the care required by resident #1, resident #2 and resident #3, in relation to the following:
a) Resident #1
- Care staff confirmed that clear directions have not been provided in relation to bathing for this resident. The resident had a wound that was being dressed and care directions are not clear with respect to how the bathing activity is to occur while the resident has this wound.
- The resident's wound was infected and care staff confirmed that clear directions were not provided in relation to the prevention of the spread of infection in this wound.
- Documentation in the clinical record indicated that the resident verbalized pain related to the wound and staff documented that at times the pain the resident experienced was horrible and excruciating. Registered staff confirmed that care to be provided to the resident in relation to pain assessment and management was not clear.
- The plan of care directed staff to ensure the resident is wearing non slip well fitting footwear, however this information conflicts with the progress notes that indicated the resident wears a bootie to accommodate the wound dressing and protect the wound.
-The care plan indicated that the resident's skin was intact, however this information conflicted with the wound assessment sheets and the wound tracking sheet that indicated the resident has a wound.
-The plan of care indicated that foot care for this resident was "normal" but did not provide clear direction of what was considered normal foot care for this resident. This information conflicted with the identified care needs the resident had in relation to an infected dressed wound.
b) Resident #2
- Care staff confirmed that the care plan did not provide clear direction to staff with respect to bathing when it identified that this resident prefers a tub bath for all baths and directed staff not to immerse the resident into bath water. The plan of care does not contain directions for staff with respect to how this activity of daily living is to be accomplished.
- Documentation in the progress notes indicated that the resident complained of pain related to a wound, but that staff is not to provide analgesic as per the resident's wife. Registered staff confirmed that the plan of care does not provide clear directions with respect to pain assessment and management for this resident including any non pharmacological interventions for pain management.
-The care plan indicated that the resident had a skin ulcer on the a lower extremity, however the progress notes and the wound tracking sheet indicated that the resident's skin ulcer was in a different location.
- The nutritional care plan indicated that the resident's skin ulcers were resolved, however the resident is identified as having a skin ulcer on a lower extremity.
c) Resident #3
- Clear directions have not been provided to staff, when the care plan indicated that the resident receives a shower in the evening and the treatment administration record indicated that staff is not to get an identified body part wet in the bath or shower. Care staff confirmed that the documents used by care staff to provide care to the resident did not provide clear directions with respect to how the bathing activity should occur while not getting this body part wet.
- The clinical record identified that the resident complained of pain from the wound, for which the resident had been given Tylenol. The care plan identified that the resident had back pain for which he receives a narcotic analgesic, however the care plan did not provide directions to staff providing care in relation to pain assessment and management related to the wound.
- The care plan related to foot care indicated that the resident has one or more foot problems but did not clarify what specific foot problems this resident had and clear directions have not been provided about what care the resident required based on issues with his feet.
2. The licensee did not ensure that the resident's substitute decision maker(SDM)or others designated by the (SDM) were given an opportunity to participate fully in the development and implementation of the resident's plan of care, in relation to the following: [6(5)]
Staff in the home did not provide the opportunity for residient #1's SDM to participate in the development of the resident's plan of care, when they did not notify the SDM of the worsening condition of resident #1's wound. Staff document in the clinical record that the wound was worsening, the wound area was larger, there were blackened areas

around the wound and there was a foul odor. The SDM was unavailable and had designated another family member to perform the duties as SDM, however staff did not notify the person designated by the SDM of the worsening conditioning of the wound. Staff in the home contacted the designate SDM six days after they identified the worsening wound condition to inform the SDM that the resident was being transferred to the hospital for treatment. The resident required a surgical procedure to treat the wound while in the hospital.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #1's right to be properly cared for in a manner consistent with the resident's identified needs was fully respected and promoted, in relation to the following: [3(1) 4]
Documentation in the clinical record indicated the resident's wound had worsened, the open area was larger with black areas around the wound and a foul odor was present. Although wound cultures were taken and the physician provided a verbal ordered for a change in the dressing being applied, no action taken to address tissue death in this wound. Six days following the identification of tissue death the resident was transferred to the hospital for immediate treatment of this wound and returned to the home following treatment that included a surgical procedure to address the tissue death in this wound.

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 by ensuring that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is full respected and promoted., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs
Specifically failed to comply with the following subsections:

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.
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.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
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 skin and wound care program was implemented in the home, with respect to the following: [48(1)2]
The home's Skin and Wound Program identified by number CN-S-13-1 dated June 2012 has not been implemented in the home.
a) The program directed that a multidisciplinary care team including the Skin Care Coordinator, DOC and/or ADOC, Infection Control Coordinator, Medical Director, RN and/or RPN who has completed wound care training, physiotherapist and/or occupational therapist and/or delegate, PSWs and others as required will meet to review individual residents on as needed basis. The DOC confirmed that there is not a functioning wound care team, that there have been no meetings and wound care issues related to residents #1, #2 and #3 were not discussed by a team of staff identified in the program directions.
b) The program also directed a skin and wound plan for each resident with altered skin integrity shall be developed with, at minimum, the resident or substitute decision maker (SDM), registered staff, personal support workers (PSW), attending physician or registered nurse extended class (RNEC), the skin care coordinator and the registered dietitian. Staff in the home confirm that residents #1, #2 and #3 who have been identified as having an wounds did not have skin and wound care plans that identified for staff providing direct care the impact of these wounds on basic care being provided such as bathing, pain and ambulation. The registered dietitian also confirmed that she has not assessed the three identified residents and has not participated in the development of a skin and wound plan for these residents.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff
Specifically failed to comply with the following subsections:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provide direct care to residents received annual training in the area of skin and wound care, in accordance with O. Reg 221(1) 2, in relation to the following: [221(2) 1]
The Director of Care provided documentation indicating that 33 of 217 direct care staff received training in skin and wound care in 2011. The Director of Care confirmed that the home has not implemented a system where staff who have not attended required training programs are monitored and action taken to ensure that these staff receive the required training.

Issued on this 17th day of October, 2012

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

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) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2012_061129_0011
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Sep 13, 14, 17, 18, 19, 20, 21, 24, 25, 27, 2012
Licensee / Titulaire de permis :	955464 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	MILLENNIUM TRAIL MANOR 6861 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANGELA MERZANIS

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that every resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to promote healing. [50(2)(b)ii]

Grounds / Motifs :

1. Resident # 1 did not receive immediate treatment and interventions to promote healing of a skin ulcer, relation to the following events:
a) No action was taken when staff documented in the clinical record that necrosis was identified in the wound. Staff and the clinical record confirmed that information identifying a significant deterioration in the resident's wound was not provided to the resident's physician and that there was not a change in the treatment plan for this resident.
b) Immediate action was not taken when staff documented in the clinical record that resident #1's wound was worsening, the open area is larger, there were blackened areas around the wound and there was a foul odor present. Staff and the clinical record confirmed that action to address the worsening condition of this wound and and particularly the death of living tissue was not taken for 6 days following staff being aware of the condition of the wound when a Registered Nurse Extended Class (RNEC) assessed the resident and immediately ordered the resident transferred to hospital for further assessment and treatment of this wound.
c) The resident returned to the home following treatment in hospital which included a significant surgical procedure. (129)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 12, 2012

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 : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that the written plan of care for resident #1, resident #2 and resident #3, sets out clear directions to staff and others who provide direct care with respect to bathing and activities of daily living that are impacted by wounds, wound infection prevention and control, pain and pain management as well as skin and wound care. [6(1)(c)]

Grounds / Motifs :

1. Previous non compliance identified on December 14, 2012 as a VPC and on April 6, 2011 as a VPC.
2. Three of three residents reviewed did not have written plans of care that set out clear directions for staff and others who provide direct care to resident #1, resident #2 and resident #3, as follows:
a) Resident # 1 had an wound and the plan of care did not provide clear directions with respect to activities such as bathing and foot care, wound infection prevention and control, pain and pain management related to expressions of pain from this wound, as well as skin and wound care strategies.
b) Resident #2 had a wound and the plan of care did not provide clear directions with respect to bathing, pain and pain management related to expressions of pain from this wound as well as skin an wound care strategies.
c) Resident #3 had a wound and the plan of care did not provide clear directions with respect to hygiene and bathing issues as well as pain and pain management related to expressions of pain from this wound. (129)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 12, 2012

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

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 :

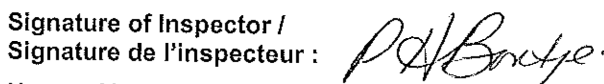
À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 27th day of September, 2012

Signature of Inspector / Signature de l'inspecteur :



Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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