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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 8, 2017	2017_482640_0011	009594-17, 009968-17, 013158-17, 013554-17, 013558-17, 013561-17	Complaint

Licensee/Titulaire de permis

488491 ONTARIO INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

AVALON RETIREMENT CENTRE
355 BROADWAY AVENUE ORANGEVILLE ON L9W 3Y3

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

HEATHER PRESTON (640)

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): June 21, 22, 26, 27, 28, 29 and July 5, 2017

During the inspection, the Long Term Care Homes Inspector toured the home, observed the provision of resident care, reviewed resident clinical records, personnel files, staff training records and relevant policies and procedures, and interviewed residents and staff.
During the course of the inspection, the following Critical Incidents and Complaints were inspected;

Complaint Inspections;
Log #009594-17 related to complaint regarding medication administration
Log #009968-17 related to complaint regarding medication administration

Critical Incident Reports;
Log #013561-17 related to missing controlled substance
Log #013158-17 related to missing controlled substance
Log #013554-17 related to missing controlled substance
Log #013558-17 related to missing controlled substance

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Co-Director of Care (s), Pain Lead, Care and Service Coordinator for Quality, Regional Care and Services Coordinator, Pharmacist, Pharmacy Manager, Physiotherapist, Physiotherapist Assistants, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurse, Personal Support Workers and Residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication
Pain

During the course of this inspection, Non-Compliances were issued.

13 WN(s)
5 VPC(s)
8 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed medication errors. The inspection revealed that a registered staff failed to administer prescribed medications to 10 different residents on 14 occasions. Medication Incident forms for all 14 incidents were submitted as per the home's policy. The registered staff was required to review the College of Nurses of Ontario practice standard on Documentation Administration of Medication, and in addition, if the behaviour continued, further discipline would be imposed up to and including termination. A second written warning was imposed for failing to sign for medications as administered. There was an expectation of proper documentation to occur and the licensee was to provide supervision to ensure the problem was rectified. There was no documentation to confirm this had occurred. The registered staff met with the home to discuss a medication error. Re-education was given regarding the incident and the appropriate process to manage in the future. A conversation was held regarding pain assessments, documentation and narcotic administration. The appropriate process was reviewed.
PSW staff noted a resident to be lethargic and unable to assist, as per usual, with the activities of daily living. They reported this to the registered staff who assessed the resident. The required treatment was not provided to the resident. The nurse on the following shift noted changes in the resident and provided the treatment as ordered by the physician.
A Decision Making Leave Re: Performance was issued to the registered staff related to several medication errors and not providing treatment as ordered. Additional education regarding medication practice and medication administration was required to be completed by the registered staff prior to returning to work.
The registered staff returned to work and continued to make errors in the administration of medication and treatments. The registered staff was subsequently terminated and the College of Nurses of Ontario notified as required.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 assessed using a clinically appropriate assessment instrument.

i) During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed the clinical record of resident #003.
According to a Medication Administration Record (MAR), the resident was receiving treatment.
The home's policy directed staff that every resident upon admission, and at other times, will have a comprehensive assessment completed in Point Click Care.
A review of the clinical record, by the LTCH Inspector, revealed the last clinically appropriate assessment instrument completed was upon admission.
The LTCH Inspector interviewed Registered Practical Nurse #104, #116 and #117 who all told the LTCH Inspector other than the documentation of a brief assessment, there were no further requirements for staff to complete any further assessment of the resident.

Interview with the Care and Service Coordinator for Quality, who explained it was expected that staff were to complete the home's clinically appropriate assessment instrument, in Point Click Care and that had not occurred.
There was no clinically appropriate assessment instrument completed for resident #003.

ii) During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed the clinical record of resident #001. The clinical record revealed the last date of a clinically appropriate assessment was completed upon admission.
The home's policy directed staff that every resident upon admission and at other identified times was to have a comprehensive assessment completed in Point Click Care.

Resident #001 had been prescribed treatment.
Upon review of two consecutive months in 2017, Medication Administration Records

(MAR), they identified several occasions where the resident required treatment.
Interview with Registered Practical Nurse #104, the RPN administering the treatment, who told the LTCH Inspector they were unaware of the need to complete an assessment using a clinically appropriate assessment instrument. Interview with the Care and Service Coordinator for Quality who told the LTCH Inspector it was an expectation of the home that a clinically appropriate assessment instrument be completed when a resident required treatment.
There were no clinically appropriate assessment instruments completed. [s. 52. (2)]

iii) During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed the clinical record of resident #005.
The orders for the resident included a number of treatments.
Review of the resident's Medication Administration Record (MAR) revealed that on several occasions, resident #005 was administered treatment.
The home's policy directed staff that every resident upon admission and at other identified times have a comprehensive assessment completed in Point Click Care.
The clinical record did not include a clinically appropriate assessment instrument completed for any of the dates.
Interview with Registered Practical Nurse #104, #116 and #117 who told the LTCH Inspector they were unaware of the need to complete an assessment using a clinically appropriate assessment instrument. Interview with the Care and Service Coordinator for Quality who told the LTCH Inspector it was an expectation of the home that a clinically appropriate assessment instrument be completed.
There were no clinically appropriate assessment instruments completed related to the treatment for resident #005. [s. 52. (2)]

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 O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that monthly audits were undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

As a result of a complaint inspection related to medication incidents including unaccounted for medications, the LTCH Inspector requested to view a copy of the monthly audits completed for daily count sheets of controlled substances for all home areas within the home.
During the inspection time the Administrator informed the LTCH Inspector that audits of the daily count sheets were not available.
The Administrator faxed a copy of audits completed on the daily count sheets of controlled substances, and confirmed there were no audits of the daily counts sheets for controlled substances completed in the home as required.
The controlled substance audit for 2 North was completed on an identified date in June 2017, which revealed a medication count sheet missing signature. No action identified to rectify the missing signature. On an identified date in June 2017, 2 South unit completed the controlled substance audit which identified a shift count sheet missing signatures on three pages. No action taken was documented to rectify the missing signatures.
The licensee failed to ensure that monthly audits were undertaken of the daily count sheets of controlled substances. [s. 130. 3.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

During a complaint inspection regarding medication management, the Long Term Care Home (LTCH) Inspector reviewed Medication Incident Forms;
(i) Medication Incident Form was reviewed regarding a medication administered without a physician order. Review of the residents Medication Administration Record (MAR) identified that resident #011 had received their prescribed medication at the correct administration time. At a later time on the same date, there was a notation made by RPN #104, on resident #005's Medication Administration Record for the as needed (prn) medication, as one dose administered to resident #011. Resident #011 had a routine order for this medication.
Review of the clinical record revealed there was no order for resident #011 to receive the prn medication identified in the clinical record.
Review of resident #011's clinical record revealed no documentation on the resident's progress notes or Medication Administration Record (MAR) regarding the administration of the medication by RPN #104.
During an interview with RPN #104 with the LTCH Inspector, they told the LTCH

Inspector there was no order to administer the identified medication and confirmed administering the medication and confirmed they did not have a physician order for this medication.
(ii) A Medication Incident Report was reviewed which revealed that resident #011 was administered a medication.
Review of resident #011’s clinical record by the LTCH Inspector noted the order for the medication was ordered after the administration of the medication. Review of resident #011’s clinical record revealed no documentation on the resident’s progress notes or Medication Administration Record (MAR) regarding the administration of the medication by RPN #104. During an interview of RPN #104 by the LTCH Inspector, they confirmed they did not have an order to administer the medication and they could not recall as to why the medication was administered without a physician order.
The Care and Service Coordinator for Quality for the home confirmed to the LTCH Inspector it was an expectation of the home that prior to administration of medication that the medication was to be prescribed by a physician. The Care and Service Coordinator confirmed that RPN #104 did not have a physician order to administer the medication to resident #004 and resident #011. [s. 131. (1)]

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed medication error reports. The inspection revealed 14 incidents where RPN #104 failed to administer medications as prescribed to ten residents.
Specifically, ten residents MAR had documentation validating the administration of their required medications at certain times but on 14 occasions, the medications had not been administered and were found to remain in the medication cart.
The LTCH Inspector interviewed RPN #104 regarding the 14 incidents. The RPN told the LTCH Inspector they did not know why this had occurred and was not aware of the omissions of medication administration. They told the LTCH Inspector there had been extenuating circumstances and as a result they were unable to provide safe medication administration.
During an interview with the Director of Care (DOC) and the Administrator, they confirmed RPN #104 failed to administer the stated medications to the residents in accordance with the directions specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 004, 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provided direct care to residents; 4. Pain management, including pain recognition of specific and non-specific signs of pain.

During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed additional training related to pain as a result of a number of non-compliance regarding pain management. The LTCH Inspector interviewed RPNs #104 and #116. During the course of the interview, the RPNs told the LTCH Inspector they did not recall having had training or education related to pain management including pain recognition of specific and non-specific signs of pain. Interview with the Pharmacist Consultant by the LTCH Inspector revealed they had asked the home if any clinical education was needed and no request had been made since the transition to the new pharmacy service provider in November 2016. The Pharmacy Lead had provided training to the home strictly related to the transition to the new provider and their processes and policies in October 2016. Training documents received from the Administrator revealed training provided to 100 percent non-registered staff was completed over the 2016 year consisted of how residents with dementia may express their pain. The training provided to 100 percent of registered staff over the course of 2016, was how to complete the PAIN-AD screening tool. No further education related to pain management to include pain recognition of specific and non-specific signs of pain was provided to the staff by the home. [s. 221. (1) 4.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was (b) reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or registered nurse in the extended class attending the resident and the pharmacy service provider

During a complaint inspection related to medication incidents in the home, the Long Term Care Home (LTCH) Inspector reviewed and inspected several Medication Incident Forms. A total of seven of the reviewed forms did not include the reporting of the medication incident to all required parties. Specifically;
(i) Resident #002, #009, #012, #014 and #018 were not administered their routine doses of medications. Resident #002, #009, #012, #014 and #018, their substitute decision-maker, the Medical Director and the prescriber were not informed of the omissions.
(ii) Resident #006 was not administered their routine dose of a certain medication. The substitute decision-maker, Medical Director and the prescriber were not informed of the omission.
(iii) Resident #015 was not administered two doses of their routine medications. The substitute decision-maker, Medical Director and the prescriber were not informed of the omission.
(iv) Resident #006 was not administered their routine medications. The substitute decision-maker, Medical Director and the prescriber were not informed of the omission.

The clinical records of all residents were reviewed and the LTCH Inspector did not identify any documentation related to the required notification regarding the omission of medications. The Medication Incident Forms when reviewed did not identify that the required notifications had been completed. Interview with the Care Service Coordinator for Quality by the LTCH Inspector, who confirmed the required notifications had not been completed as expected by the home. [s. 135. (1)]

2. The licensee failed to ensure that every medication incident involving a resident was (a) documented, reviewed and analyzed; (b) corrective action was taken as necessary and (c) a written record was kept of everything required under clauses (a) and (b

As a result of a complaint inspection related to medication incidents, the Long Term Care Home (LTCH) Inspector reviewed all Medication Incident Reports for a two month period in 2017. The home was requested by the LTCH Inspector to supply all Medication Incident Reports, all investigative notes and information gathered as a result of the investigation and the review and analysis of the medication incidents. The home was not able to supply to the LTCH Inspector the investigative notes or the required documentation related to the review and analysis of the medication incidents.
During an interview with the Director of Care, they informed the LTCH Inspector that they did not document or analyze the medication incidents for the home.
During an interview with the Pharmacist Consultant, the LTCH Inspector was informed the number of medication incidents was reported at the Professional Advisory Committee

by the Pharmacist Consultant, but there was no analysis carried out to determine trends or necessary corrective action.
During an interview with the Administrator, the LTCH Inspector was informed the home did not have documentation related to the review and analysis of medication incidents or corrective action taken. [s. 135. (2)]

3. The licensee failed to ensure that (a) a quarterly review was undertaken of all medication incidents that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents; (b) any changes and improvements identified in the review were implemented; and (c) a written record was kept of everything provided for in clauses (a) and (b).

As a result of a complaint inspection related to medication incidents, the LTCH Inspector requested from the home, the quarterly review of all medication incidents to include the changes and improvements identified and implemented. The Administrator explained to the LTCH Inspector that the quarterly medication incident reviews were incorporated into their Professional Advisory Council (PAC) which met on a quarterly basis. The LTCH Inspector reviewed the PAC minutes from a certain date, and found the following; Medication Error Report – Month A, one total: medication container broken. Month B, one total: one medication not in pouch, one order not on eMAR. Month C, one total: medication not in pouch. The "Action Outcome" column for this item stated the Director of Care. The "Who" column stated "Continues".
A review of a second PAC meeting revealed the following; Med Error Report – six medication errors in total for Month D. Two pharmacy related and four nurse related. No harm came to residents in all errors. All nurses involved have had counseling related to their error. Eight medication errors in total for Month E. One involved a nurse administering medication at the wrong time, four were pharmacy errors, one was found still in the pouch but documented as refused. One was a medication administered to the wrong resident and the other was signed on eMAR but still found in pouch. The last one was a medication given prior to an order from the doctor. Five medication errors in total in Month F. One was a wrong medication was administered by a student nurse, one was the wrong type of medication was administered, two were pharmacy error and one was a pharmacy error related to computer entry of medications.
The LTCH Inspector interviewed the Care and Services Coordinator with the Administrator who confirmed the medication incidents were not adequately reviewed quarterly to reduce and prevent medication incidents and changes were not identified and therefore not implemented. [s. 135. (3)]

Additional Required Actions:

CO # - 007, 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During a complaint inspection, the Long Term Care Homes (LTCH) Inspector reviewed the clinical record for resident #019 related to medication administration. The written plan of care did not include any direction to staff regarding method of medication administration. The electronic Medication Administration Record (eMAR), directed staff to administer medications a certain way. The medication bin belonging to resident #019,

directed staff to administer the medications a certain way. Registered Practical Nurse #109 believed the resident's medications to be administered a certain way, not in keeping with the directions on the eMAR. RPN # 106 told the LTCH Inspector that resident #019 received their medication a certain way which was not in keeping with the directions on the eMAR. RN #113 told the LTCH Inspector that resident #019's medications were to be given a certain way as per the directions on the eMAR.
During an interview with the Administrator and the Care Services Regional Coordinator, they confirmed to the LTCH Inspector that this was confusing and unclear direction to staff. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

During a complaint inspection, the Long Term Care Homes (LTCH) Inspector reviewed the clinical record for resident #019 related to medication administration. The written plan of care did not include any direction to staff regarding method of medication administration.
The electronic Medication Administration Record (eMAR), directed staff to administer medications a certain way. The medication bin belonging to resident #019 directed staff to administer medications a certain way. Registered Practical Nurse #009 believed the resident's medications to be administered a certain way which was not in keeping with the direction on the eMAR. RPN # 006 told the LTCH Inspector that resident #019 received their medication a certain way which was not in keeping with the directions on the eMAR. During an interview with the Administrator and the Care Services Regional Coordinator, they confirmed to the LTCH Inspector that this was confusing, was not consistent and did not complement each other. [s. 6. (4) (b)]

3. The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #003 was admitted to the home and had a Minimum Data Set (MDS) assessment. During an interview with the resident, the resident told the LTCH Inspector their symptoms were not treated. The resident was aware of the medication they were taking to relieve the pain and was unaware of any other treatment available. Review of the resident's Medication Administration Record (MAR) noted the resident to have a treatment available as needed. The MAR for a two month period revealed that the

resident had not had the treatment on any date during the two months reviewed. Interview with Registered Practical Nurses #104, #116 and #117 and RN #105 did not identify the availability of this intervention. All staff confirmed they had not used this treatment and that it may have been effective for the resident had it have been used. [s. 6. (7)]

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 each residents plan of care sets out clear direction to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #8: 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. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including a medication management program, were developed and implemented in the home and each program must, in addition to meeting the

requirements set out in section 30, provide for relevant policies, procedures and protocols and provide for methods to reduce risk and monitor outcomes. O. Reg. 79/10, s.48

During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed Medication Incident Forms;
(i) The LTCH Inspector reviewed multiple medication incidents with the Administrator and the Care Service Coordinator for Quality. As a result of the home's further investigation into a missing medication, the home found three loose tablets in the bottom drawer of a medication cart. The three tablets were put in a plastic ziplok bag and placed at the back of the locked medication box in the bottom drawer of an active medication cart. The tablets were reviewed by the Pharmacist Consultant who determined what one of the medications were. The remaining two tablets had not been identified.
The home's policy entitled Resident Rights, Care and Services – Medication Management – Drug Disposal and Wasting of Medications, revised April 7, 2017, directed staff to remove from current medication supplies, medications which were discontinued, unused, expired, recalled, deteriorated, unlabeled and in containers with worn, illegible, damaged incomplete or missing labels. Surplus medications were to be stored in a secure area of the medication room under double lock in a permanently affixed cabinet. Surplus non-narcotic medications were to be stored in a secure area of the medication room. Interview with the Care and Services Coordinator who confirmed to the LTCH Inspector, the bag of three tablets were expected to be removed from the current medication supplies.
The home did not ensure that staff followed their policy regarding the unlabeled medications and stored the unidentified medications in the active medication cart with medications currently in use.
(ii) According to the home's policy Resident Rights, Care and Services – Medication Management – Drug Disposal and Wasting of Medications, revised April 7, 2017, staff was directed that when wasting a controlled medication that was refused, the registered staff was to sign the electronic Medication Administration Record (eMAR) as refused. Two registered staff were to sign the Controlled Substance Administration Record after both registered staff had witnessed the wasting of the medication. RPN #104 had signed on resident #003's Controlled Substance Administration Record, that a prn medication was wasted at a specific time. Review of the eMAR by the LTCH Inspector, identified that the eMAR had not been signed by the RPN and it did not include the code of "2" indicating the resident refused the medication. During an interview with RPN #106, they told the LTCH Inspector they had been asked the following day, by RPN #104, to sign the document for a wasted medication. RPN #106 did not realize until later in their shift,

that what they had signed for was a wasted medication from the previous day. The LTCH Inspector interviewed RPN #104 who told them that they had wasted the medication themselves as the resident had refused the medication. During an interview with the Care and Services Coordinator, they explained the home expected that two registered staff were to witness and then sign for any wasted narcotic medication and this had not occurred. The home did not ensure that staff followed their policy regarding wasting of a narcotic medication.
(iii) Review of a Medication Incident Form by the LTCH Inspector related to an incident wherein RPN #104 had administered resident #003's as needed (prn) dose of a medication. The Controlled Substance Administration Record was signed by RPN #104 with an administration time prior to the time signed for on the eMAR. Review of the Medication Administration Record (MAR) by the LTCH Inspector identified the documented time of administration to be a specific time. The LTCH Inspector reviewed a Medication Administration Audit Report for resident #003 and the report revealed the scheduled date and time was documented eight days following the administration of the medication. The home's policy Resident Rights, Care and Services – Medication Management – Administration of Medications, Version 2 and revised July 24, 2015, directed staff to document the administration of medications on the Medication Administration Record following the administration of the medication. During an interview with the Care Services Coordinator, they told the LTCH Inspector that it was an expectation of the home that medications were to be documented in the eMAR once they had been administered to the resident. They also confirmed that had not occurred. The home did not ensure that staff followed their policy regarding documentation of administered medications.
(iv) During an interview with RN #105, they told the LTCH Inspector that RPN #104 had signed for, but not administered a medication to resident #006 at a specific time. During the shift medication count, RN #105 found there to be an extra medication in the medication card for resident #006. They asked RPN #104 why the medication remained in the card. RPN #104 told RN #105 the resident had refused their medications that morning. The LTCH Inspector reviewed resident #006's eMAR. RPN #104 had signed the medication as being administered at the prescribed time. They had gone back in to the eMAR and struck out several medications at a specific time with a comment. There were no changes made to the documentation regarding the other medications. Review of the clinical record of resident #006 by the LTCH Inspector noted no documentation related to the resident spitting out medication or otherwise not receiving their prescribed doses. According to the home's policy, Resident Rights, Care and Services – Medication Management – Administration of Medications, Version 2 and revised July 2, 2015, staff were directed to document any pertinent and related information in the multidisciplinary

record as applicable. During an interview with RPN #104, the RPN told the LTCH Inspector the resident had refused the medication. RPN #104 did not have clear recall as to why the medication remained in the medication card and signed as administered on the eMAR. The LTCH Inspector interviewed the Care and Services Coordinator who verified that the policy was not followed regarding documentation related to the resident spitting out the medication and the medication had been signed prior to administration by RPN #104. The licensee did not ensure the home followed their policy regarding the administration and documentation of medications. [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 staff comply with the home's relevant policies, procedures and protocols, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee failed to ensure that all the staff of the home, including the persons mentioned in sections 70 to 72, (a) had the proper skills and qualifications to perform their duties.

During a medication management inspection as a result of two complaints, the Long Term Care Home (LTCH) Inspector reviewed the clinical records of residents # 001, #003 and #005, interviewed staff, the Director of Care, the Administrator, the home’s Quality Consultant, residents, RPN #104 and reviewed the personnel file of RPN #104.

As a result of the inspection, the following was discovered that was known to the home, as having occurred, being directly related to RPN #104's skill and actions; missed treatments; no documentation regarding a change of condition for a resident, the treatment provided and the outcome of the treatment; no signature when medications were administered; medication errors and no assessment of a resident who was administered multiple treatments.
The RPN was to report to the nurse manager or delegate at the end of each shift to review the medication cart and show them the dashboard indicating that all prescribed medications were signed for. Staff was not directed to ensure that medications the RPN had signed for as administered had been given as prescribed.

Interview with the Nurse Manager and the delegate by the LTCH Inspector revealed there was no direction given by the DOC as to the specifics of the medication cart review. The delegate, the Charge Nurse on the weekend, was not aware that anything was to occur and the RPN did not notify them at the end of either weekend shift. CoDOC #102 was also not informed of the requirements when RPN #104 was on duty.
The DOC was not aware that the end of shift reviews had not occurred at the end of each shift worked by RPN #104.

ii) Medication concerns that occurred after the one day suspension of RPN #104 who returned to work;
a) Narcotic wasted without a second nurse present
b) Narcotic signed as administered but remained in the narcotic card
c) RPN #104 administered medications to a resident that were not prescribed to be given during their shift. A fellow nurse saw the medication cup which was left with the resident and it was not the correct medication prescribed to the resident.
d) Narcotic administered but not signed on the eMAR as administered
e) eMAR signed as medications administered for two doses on the same day however, the pouches with the medications remained in the medication cart
f) Narcotic found in medication card that was to have been administered. The eMAR was signed as administered by RPN #104.

iii) Medication concerns regarding RPN #104 identified by the LTCH Inspector during course of the inspection which created potential risk of harm to the residents;
a) Narcotic analgesic was administered to residents on two occasions, without a physician's order
b) Administration of a narcotic analgesic to resident #011 was not documented
c) On 14 occasions, RPN #104 did not administer medications as prescribed and had

documented as administered
d) Documentation of narcotic analgesic administration occurred eight days after the reported administration
e) RPN #104 documented a narcotic had been wasted but had done so without a second nurse
f) a narcotic analgesic had been signed for as administered by RPN #104, however it was found to be in the medication card at shift count

The Director of Care had ongoing knowledge that RPN #104 did not demonstrate the appropriate skill to safely administer medications in accordance with the home's policy and procedure and the Medication Standard as set out by the College of Nurses of Ontario (CNO). At the conclusion of the inspection, the home terminated the RPN's employment and informed the CNO of the termination with a brief summary of events leading up to the termination. [s. 73. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all the staff of the home, including the persons mentioned in sections 70 to 72, (a) have the proper skills and qualifications to perform their duties, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

As a result of a complaint inspection related to medication incidents, the Long Term Care Home (LTCH) Inspector requested a copy of the annual medication program evaluation from the home. The LTCH Inspector was given the meeting minutes from Quality Council from the Administrator. The Care and Service Coordinator informed the LTCH Inspector the annual evaluation was identified as the completion of The Institute for Safe Medication Practice (ISMP) within those minutes. The meeting minutes identified that the Medical Director, the Administrator, the pharmacy service provider and the registered dietitian were not present at the annual evaluation of the medication management system. The licensee failed to ensure that an interdisciplinary team met annually to evaluate the medication management system. [s. 116. (1)]

2. The licensee failed to ensure that the annual evaluation of the medication management system included (a) a review of the quarterly evaluations in the previous year as referred to in 115; (b) be undertaken using an assessment instrument designed specifically for this purpose; and (c) identify changes to improve the system in accordance with evidence-based practices and if there were none in accordance with prevailing practices.

As a result of a complaint inspection related to medication incidents, the Long Term Care Home (LTCH) Inspector requested a copy of the annual medication program evaluation from the home. The LTCH Inspector was given the meeting minutes from Quality Council. The Care and Service Coordinator informed the LTCH Inspector the annual evaluation was identified as the completion of a Medication Institute for Safe Medication Practice (ISMP). The documentation did not identify a review of the quarterly evaluations in the previous year and the identification of any changes made to improve the system in accordance with evidence-based practices. The ISMP tool used for the purpose of the annual evaluation of the medication management system was not an assessment instrument designed specifically for the purpose. The licensee failed to ensure an annual evaluation of the medication system was completed as required. [s. 116. (3)]

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 there is an annual evaluation of the medication management system using an assessment instrument designed specifically for this purpose, identify changes to improve the system in accordance with evidence-based practices and if there are none in accordance with prevailing practices and that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meet annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #11: 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 failed to ensure that (a) drugs were stored in an area or a medication cart that (i) was used exclusively for drugs and drug-related supplies and (ii) that was secure and locked.

During a complaint inspection, the Long Term Care Home (LTCH) Inspector interviewed Co-Director of Care #102 and the Resident Assessment Instrument Coordinator (RAI) related to their participation in investigating medication incidents.
(i) Co-DOC #102 explained to the LTCH Inspector that they received four or five pouches of resident medications from the Director of Care (DOC), with contents intact. The medications were not administered as directed by RPN #104. The Co-DOC was directed by the DOC to write the incident reports and was not directed to investigate. The Co-DOC told the LTCH Inspector they did not have time to do the documentation, left the medication pouches with their contents intact, on their desk then went on vacation. The office was shared with three other staff members. When the Co-DOC returned from vacation the medication pouches were no longer on the desk. They were not aware of where the medication pouches may have gone or who may have picked them up. Co-DOC was directed to investigate missing medication for resident #011 but did not investigate the incident. The Co-DOC confirmed the storage of the medications was not appropriate and they should have been in a secure, locked area used exclusively for drugs.
(ii) Interview with the RAI Coordinator who told the LTCH Inspector they were directed by the DOC to complete incident reports for four or five pouches of medications, complete with contents, which had not been administered by RPN #104. The RAI Coordinator completed the incident reports, photocopied the medication pouches and placed the incident report, the photocopy of the medication pouches and the pouches of medication in the mail slot over the weekend for the DOC to pick up the following week. The RAI Coordinator was unaware if or when the package of information and attached pouches of medications were picked up by the DOC.
The licensee failed to ensure that drugs were stored in an area exclusively for drugs and was secure and locked. [s. 129. (1) (a)]

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 a) drugs are stored in an area or a medication cart that (i) is used exclusively for drugs and drug-related supplies and (ii) that is secure and locked, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (1) Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers. 2007, c. 8, s. 75. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that screening measures were conducted in accordance with the regulations before hiring staff and accepting volunteers and (2) the screening measures included criminal reference checks, unless the person being screened was under 18 years of age, 2007, c. 8, s. 75(1) and (2).

During a complaint inspection regarding medication management, the Long Term Care Home (LTCH) Inspector reviewed the personnel record of Registered Practical Nurse (RPN) #104 which revealed the date of hire, and required a criminal reference check to include a vulnerable sector screen. The employee's personnel record did not contain a criminal reference check conducted by a police force nor a vulnerable sector screen. During an interview with the Administrator by the LTCH Inspector, the Administrator confirmed the home did not have a criminal reference check conducted by a police force nor a vulnerable sector screen for RPN #104. The Administrator confirmed that both were a requirement prior to hiring the RPN. [s. 75. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day regarding missing or unaccounted for controlled substances.

(i) During a complaint inspection regarding medication management, the Long Term Care Home (LTCH) Inspector reviewed medication incidents from an identified date in March 2017, up to and including an identified date in June 2017. The inspection revealed on an identified date in April 2017, a medication was found to be tampered with. RN #113 went to dispense the medication when they discovered the medication package had been taped over and the medication had an asymmetrical appearance and no contents. An Incident Report was completed by RN #113 immediately and faxed to the Pharmacy service provider and the original was left for the Director of Care (DOC). The incident occurred on a identified date in April 2017, and was reported to the Director

on an identified date in June 2017.
The pharmacy's medication incident response was faxed to the home on an identified date in April 2017, and was addressed to the Administrator and the DOC.
During an interview with the Administrator, they told the LTCH Inspector that an investigation was expected to have occurred and was expected to be immediately initiated. The Administrator confirmed that a Critical Incident Report had not been submitted and that it was an expectation that this was to occur within one business day.
(ii) On an identified date in May 2017, resident #003 had been seen to have a paper medication cup with three medications on their walker by RPN #106 as they left for the day. The RPN reported this observation to RN #105, the nurse in charge on the evening shift. The medications administered by RPN #104 were to be administered by RN #105 as they were the nurse on the evening shift. Upon investigation by the RN, it was discovered that RPN #104 had documented administering two of the medications to the resident and had not documented administration of the incorrect medication as administered. Both registered staff confirmed at the time of the occurrence and during interview with the LTCH Inspector, that the medication was not what was ordered by the physician. During interviews with RPN #106 and RN #105, who both stated they did not report this nor did they complete an incident report. During an interview with RPN #104, they told the LTCH Inspector they had no recollection of what occurred. The LTCH Inspector informed the Administrator of the incident. During an interview with the Administrator, they told the LTCH Inspector that an investigation was expected to have immediately been initiated. The Administrator confirmed that a Critical Incident Report had not been submitted and that it was an expectation that this was to occur within one business day. The Administrator initiated an immediate investigation and submitted a report to the Director. The incident was reported to the Director several weeks after the occurrence. [s. 107. (3)]

Issued on this 31st day of October, 2017

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

Original report signed by the inspector.

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2017_482640_0011
Log No. / No de registre :	009594-17, 009968-17, 013158-17, 013554-17, 013558-17, 013561-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 8, 2017
Licensee / Titulaire de permis :	488491 ONTARIO INC 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	AVALON RETIREMENT CENTRE 355 BROADWAY AVENUE, ORANGEVILLE, ON, L9W-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jodi Napper-Campbell

To 488491 ONTARIO INC, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

(1) The Licensee shall prepare and implement a plan and strategies to ensure that residents are not neglected by the licensee or staff. Ensuring that all residents receive medications as prescribed, including as necessary (PRN) medications.
(2) The Licensee shall ensure that all registered staff receive re-training regarding medication administration and neglect as it relates to the omission of prescribed medication and the reporting of medication errors, and
(3) The Licensee shall ensure that appropriate action is taken to protect residents in the home when medication errors occur.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm, a scope of widespread and a compliance history in the last three years of "one or more unrelated non-compliance".

The licensee failed to ensure that residents were not neglected by the licensee or staff.

During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed medication errors. The inspection revealed that a registered staff failed to administer prescribed medications to 10 different residents on 14 occasions. Medication Incident forms for all 14 incidents were submitted as per the home's policy. The registered staff was required to review the College of Nurses of Ontario practice standard on Documentation Administration of Medication, and in addition, if the behaviour continued, further discipline would be imposed up to and including termination. A second written warning was imposed for failing to

sign for medications as administered. There was an expectation of proper documentation to occur and the licensee was to provide supervision to ensure the problem was rectified. There was no documentation to confirm this had occurred. The registered staff met with the home to discuss a medication error. Re-education was given regarding the incident and the appropriate process to manage in the future. A conversation was held regarding pain assessments, documentation and narcotic administration. The appropriate process was reviewed.
PSW staff noted a resident to be lethargic and unable to assist, as per usual, with the activities of daily living. They reported this to the registered staff who assessed the resident. The required treatment was not provided to the resident. The nurse on the following shift noted changes in the resident and provided the treatment as ordered by the physician.
A Decision Making Leave Re: Performance was issued to the registered staff related to several medication errors and not providing treatment as ordered. Additional education regarding medication practice and medication administration was required to be completed by the registered staff prior to returning to work.
The registered staff returned to work and continued to make errors in the administration of medication and treatments. The registered staff was subsequently terminated and the College of Nurses of Ontario notified as required.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

(1) Ensure that residents #001, #003 and #005 have a clinically appropriate assessment instrument specifically designed for the assessment of pain be completed and appropriate action taken as a result of the individual findings.
(2) Develop and implement a process to audit on a regular basis, whether clinically appropriate assessment instruments specifically designed for the assessment of pain have been completed as required by policy and legislation.
(4) Review the results of the initial audit findings and the ongoing results at the Pain Management Program meetings to determine actions required or necessary changes to the program.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm, a scope of widespread and a compliance history in the last three years of "one or more unrelated non-compliance".

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

iii) During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed the clinical record of resident #005.
The orders for the resident included a number of treatments.
Review of the resident's Medication Administration Record (MAR) revealed that on several occasions, resident #005 was administered treatment.
The home's policy directed staff that every resident upon admission and at other

identified times have a comprehensive assessment completed in Point Click Care.
The clinical record did not include a clinically appropriate assessment instrument completed for any of the dates.
Interview with Registered Practical Nurse #104, #116 and #117 who told the LTCH Inspector they were unaware of the need to complete an assessment using a clinically appropriate assessment instrument. Interview with the Care and Service Coordinator for Quality who told the LTCH Inspector it was an expectation of the home that a clinically appropriate assessment instrument be completed.
There were no clinically appropriate assessment instruments completed related to the treatment for resident #005. [s. 52. (2)]

(640)

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

ii) During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed the clinical record of resident #001. The clinical record revealed the last date of a clinically appropriate assessment was completed upon admission.

The home's policy directed staff that every resident upon admission and at other identified times was to have a comprehensive assessment completed in Point Click Care.
Resident #001 had been prescribed treatment.
Upon review of two consecutive months in 2017, Medication Administration Records (MAR), they identified several occasions where the resident required treatment.
Interview with Registered Practical Nurse #104, the RPN administering the treatment, who told the LTCH Inspector they were unaware of the need to complete an assessment using a clinically appropriate assessment instrument.
Interview with the Care and Service Coordinator for Quality who told the LTCH Inspector it was an expectation of the home that a clinically appropriate assessment instrument be completed when a resident required treatment.
There were no clinically appropriate assessment instruments completed. [s. 52. (2)]

(640)

3. 1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument.

i) During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed the clinical record of resident #003.
According to a Medication Administration Record (MAR), the resident was receiving treatment.
The home's policy directed staff that every resident upon admission, and at other times, will have a comprehensive assessment completed in Point Click Care.
A review of the clinical record, by the LTCH Inspector, revealed the last clinically appropriate assessment instrument completed was upon admission.
The LTCH Inspector interviewed Registered Practical Nurse #104, #116 and #117 who all told the LTCH Inspector other than the documentation of a brief assessment, there were no further requirements for staff to complete any further assessment of the resident.
Interview with the Care and Service Coordinator for Quality, who explained it was expected that staff were to complete the home's clinically appropriate assessment instrument, in Point Click Care and that had not occurred.
There was no clinically appropriate assessment instrument completed for resident #003.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2017

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 130. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Order / Ordre :

(1) Ensure that a process is developed and implemented for the completion of monthly audits of the controlled substances count sheets.
(2) Develop a plan and process to analyze the results of the monthly audits.
(3) Document and have on file, any and all actions taken to resolve identified inconsistencies found during the audit process.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm, a scope of widespread and a compliance history in the last three years of “one or more unrelated non-compliance”.

The licensee failed to ensure that monthly audits were undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

As a result of a complaint inspection related to medication incidents including unaccounted for medications, the LTCH Inspector requested to view a copy of the monthly audits completed for daily count sheets of controlled substances for all home areas within the home.
During the inspection time the Administrator informed the LTCH Inspector that audits of the daily count sheets were not available.
The Administrator faxed a copy of audits completed on the daily count sheets of controlled substances, and confirmed there were no audits of the daily counts sheets for controlled substances completed in the home as required.
The controlled substance audit for 2 North was completed on an identified date in June 2017, which revealed a medication count sheet missing signature. No action identified to rectify the missing signature. On an identified date in June 2017, 2 South unit completed the controlled substance audit which identified a shift count sheet missing signatures on three pages. No action taken was documented to rectify the missing signatures.
The licensee failed to ensure that monthly audits were undertaken of the daily count sheets of controlled substances. [s. 130. 3.]

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2017

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

(1) All registered staff to review the home's policies and procedures related to medication administration, the use of medical directives and obtaining and transcription of physician orders prior to the administration of medication.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm, a scope of widespread and a compliance history in the last three years of “one or more unrelated non-compliance”.

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

During a complaint inspection regarding medication management, the Long Term Care Home (LTCH) Inspector reviewed Medication Incident Forms;
(i) Medication Incident Form was reviewed regarding a medication administered without a physician order. Review of the residents Medication Administration Record (MAR) identified that resident #011 had received their prescribed medication at the correct administration time. At a later time on the same date, there was a notation made by RPN #104, on resident #005's Medication Administration Record for the as needed (prn) medication, as one dose administered to resident #011. Resident #011 had a routine order for this medication.
Review of the clinical record revealed there was no order for resident #011 to receive the prn medication identified in the clinical record.
Review of resident #011's clinical record revealed no documentation on the resident's progress notes or Medication Administration Record (MAR) regarding

the administration of the medication by RPN #104.
During an interview with RPN #104 with the LTCH Inspector, they told the LTCH Inspector there was no order to administer the identified medication and confirmed administering the medication and confirmed they did not have a physician order for this medication.
(ii) A Medication Incident Report was reviewed which revealed that resident #011 was administered a medication.
Review of resident #011's clinical record by the LTCH Inspector noted the order for the medication was ordered after the administration of the medication.
Review of resident #011's clinical record revealed no documentation on the resident's progress notes or Medication Administration Record (MAR) regarding the administration of the medication by RPN #104. During an interview of RPN #104 by the LTCH Inspector, they confirmed they did not have an order to administer the medication and they could not recall as to why the medication was administered without a physician order.
The Care and Service Coordinator for Quality for the home confirmed to the LTCH Inspector it was an expectation of the home that prior to administration of medication that the medication was to be prescribed by a physician. The Care and Service Coordinator confirmed that RPN #104 did not have a physician order to administer the medication to resident #004 and resident #011. [s. 131. (1)]
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2017

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

(1) All registered staff are to have face to face training regarding the recognition of specific and non-specific signs of pain and evaluate the effectiveness of the training.
(2) All registered staff are to have training related to the management of pain based on evidence-based practices or if there are none, prevailing practices for management of pain to include the pharmacological and non-pharmacological interventions for pain and evaluate the effectiveness of the training.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm, a scope of widespread and a compliance history in the last three years of “one or more unrelated non-compliance”.

The licensee failed to ensure that for purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provided direct care to residents; 4. Pain management, including pain recognition of specific and non-specific signs of pain.

During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed additional training related to pain as a result of a number of non-compliance regarding pain management. The LTCH Inspector interviewed RPNs #104 and #116. During the course of the interview, the RPNs told the LTCH Inspector they did not recall having had training or education related to pain management including pain recognition of specific and non-specific signs of pain. Interview with the Pharmacist Consultant by the LTCH Inspector revealed they had asked the home if any clinical education was needed and no request had been made since the transition to the new pharmacy service provider in November 2016. The Pharmacy Lead had provided training to the home strictly related to the transition to the new provider and their processes and policies in October 2016. Training documents received from the Administrator revealed training provided to 100 percent non-registered staff was completed over the 2016 year consisted of how residents with dementia may express their pain. The training provided to 100 percent of registered staff over the course of 2016, was how to complete the PAIN-AD screening tool. No further education related to pain management to include pain recognition of specific and non-specific signs of pain was provided to the staff by the home. [s. 221. (1) 4.]

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 13, 2017

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

(1) Develop and implement a plan to audit medication administration to ensure medications are administered as ordered by the prescriber.
(2) Develop and implement a process to analyze the results of the audits.
(3) Document the analysis and action taken as identified in the audits and have readily available.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm, a scope of widespread and a compliance history in the last three years of “one or more unrelated non-compliance”.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During a complaint inspection, the Long Term Care Home (LTCH) Inspector reviewed medication error reports. The inspection revealed 14 incidents where RPN #104 failed to administer medications as prescribed to ten residents. Specifically, ten residents MAR had documentation validating the administration of their required medications at certain times but on 14 occasions, the medications had not been administered and were found to remain in the medication cart.
The LTCH Inspector interviewed RPN #104 regarding the 14 incidents. The RPN told the LTCH Inspector they did not know why this had occurred and was not aware of the omissions of medication administration. They told the LTCH Inspector there had been extenuating circumstances and as a result they were unable to provide safe medication administration.
During an interview with the Director of Care (DOC) and the Administrator, they confirmed RPN #104 failed to administer the stated medications to the residents in accordance with the directions specified by the prescriber. [s. 131. (2)]

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2017

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee shall develop and implement a plan that includes:
1. Consultation with and participation of the Pharmacy Consultant in review of the policy related to medication errors.
2. Developing clear lines of communication that ensure timely notification of the DOC and Pharmacy when a medication error occurs.
3. All registered staff will review policy and procedure related to medication errors.
4. A process will be developed and implemented to ensure that when medication errors occur their is immediate investigation into the root cause of the error and appropriate action taken to correct any practice that resulted in an error.
5. The plan should address actions to take when a pattern of medication errors is identified for any one registrant, including notification of the appropriate college.
6. Develop and implementation of an auditing process to ensure that when medication errors occur all necessary steps are taken.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm, a scope of widespread and a compliance history in the last three years of "one or more unrelated non-compliance".

2. The licensee failed to ensure that every medication incident involving a resident was (a) documented, reviewed and analyzed; (b) corrective action was taken as necessary and (c) a written record was kept of everything required under clauses (a) and (b).

As a result of a complaint inspection related to medication incidents, the Long Term Care Home (LTCH) Inspector reviewed all Medication Incident Reports for a two month period in 2017. The home was requested by the LTCH Inspector to supply all Medication Incident Reports, all investigative notes and information gathered as a result of the investigation and the review and analysis of the medication incidents. The home was not able to supply to the LTCH Inspector the investigative notes or the required documentation related to the review and analysis of the medication incidents.
During an interview with the Director of Care, they informed the LTCH Inspector that they did not document or analyze the medication incidents for the home.
During an interview with the Pharmacist Consultant, the LTCH Inspector was informed the number of medication incidents was reported at the Professional Advisory Committee by the Pharmacist Consultant, but there was no analysis carried out to determine trends or necessary corrective action.
During an interview with the Administrator, the LTCH Inspector was informed the home did not have documentation related to the review and analysis of medication incidents or corrective action taken. [s. 135. (2)]

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2017

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review are implemented; and

(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Order / Ordre :

(1) A process is to be developed and implemented to ensure all medication incidents are reviewed and analyzed on a quarterly basis to reduce and prevent further medication incidents.
(2) Provide for a written record of the review, analysis and changes to the program as a result of the quarterly review.
(4) Develop and implement an audit tool to the ensure the implemented changes are effective.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm, a scope of widespread and a compliance history in the last three years of “one or more unrelated non-compliance”.

The licensee failed to ensure that (a) a quarterly review was undertaken of all medication incidents that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents; (b) any changes and improvements identified in the review were implemented; and (c) a written record was kept of everything provided for in clauses (a) and (b).

As a result of a complaint inspection related to medication incidents, the LTCH

Inspector requested from the home, the quarterly review of all medication incidents to include the changes and improvements identified and implemented. The Administrator explained to the LTCH Inspector that the quarterly medication incident reviews were incorporated into their Professional Advisory Council (PAC) which met on a quarterly basis. The LTCH Inspector reviewed the PAC minutes from a certain date, and found the following; Medication Error Report – Month A, one total: medication container broken. Month B, one total: one medication not in pouch, one order not on eMAR. Month C, one total: medication not in pouch. The "Action Outcome" column for this item stated the Director of Care. The "Who" column stated "Continues".
A review of a second PAC meeting revealed the following; Med Error Report – six medication errors in total for Month D. Two pharmacy related and four nurse related. No harm came to residents in all errors. All nurses involved have had counseling related to their error. Eight medication errors in total for Month E. One involved a nurse administering medication at the wrong time, four were pharmacy errors, one was found still in the pouch but documented as refused. One was a medication administered to the wrong resident and the other was signed on eMAR but still found in pouch. The last one was a medication given prior to an order from the doctor. Five medication errors in total in Month F. One was a wrong medication was administered by a student nurse, one was the wrong type of medication was administered, two were pharmacy error and one was a pharmacy error related to computer entry of medications.
The LTCH Inspector interviewed the Care and Services Coordinator with the Administrator who confirmed the medication incidents were not adequately reviewed quarterly to reduce and prevent medication incidents and changes were not identified and therefore not implemented. [s. 135. (3)]
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2017

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Heather Preston

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