Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Aug 3, 2017	2017_652625_0010	005873-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

BIRCHWOOD TERRACE
237 Lakeview Drive R. R. #1 KENORA ON P9N 4J7

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

KATHERINE BARCA (625), JENNIFER KOSS (616), JULIE KUORIKOSKI (621), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 2 to 4 and 8 to 11, 2017.

Additional intakes completed during the Resident Quality Inspection (RQI) were:
- four logs related to four Critical Incident System (CIS) reports submitted for resident to resident abuse;
- five logs related to four CIS reports submitted for improper or incompetent treatment of a resident that resulted in harm or risk to a resident;

- three logs related to three CIS reports submitted for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status;
- one log related to a CIS report submitted for staff neglect of a resident;
- three logs related to four CIS reports submitted for alleged staff to resident abuse;
- two logs related to a Follow-up to Compliance Orders #001 and #002 issued during inspection #2017_633577_0004 regarding the Long-Term Care Homes Act (LTCHA), 2007 S.O. 2007, c.8 s. 6. (7) Plan of care and Ontario Regulation 79/10, s. 213 (4) (a) Director of Nursing and Personal Care qualifications;
- one log related to a complaint regarding abuse and neglect of a resident;
- two logs related to two CIS reports submitted for unexpected deaths; and
- one log related to a Follow-up to Compliance Order #001 issued during inspection #2017_633577_0002 regarding the LTCHA, 2007 S.O. 2007, c.8 s. 8. (3) 24-hour nursing care specifically pertaining to staffing of registered nurses.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Office Manager, the Ward Clerk/Scheduler, the Social Worker, the Resident Assessment Instrument (RAI) Coding Lead/Registered Practical Nurse (RPN), the Environmental Services Manager (ESM), the Program Manager, Registered Nurses (RNs), RPNs, Personal Support Workers (PSWs), a Pharmacist, residents and family members.

The Inspectors also reviewed resident health care records, various home's policies and procedures, employee personnel files, the home's investigation files and council meeting minutes. Inspectors conducted observations of residents, observed the provision of care and services to residents, observed resident and staff interactions, home areas, meal services and conducted a tour of resident care areas.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_633577_0004	625

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During inspection #2017_633577_0002 Compliance Order #001 was issued pursuant to the Long-Term Care Homes Act, 2007, s. 8. (3). The licensee was ordered to ensure that there was at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, except as provided for in the regulations, with a compliance date of March 22, 2017.

Inspector #625 reviewed the home's "Sign in Sheets" from March 22, 2017, to May 8, 2017, and identified that there had been no registered nurse (RN) on site in the home on Sunday, April 16, 2017, from 0700 to 0900 hours; on Wednesday, April 26, 2017, from 0700 to1900 hours; and on Saturday, April 29, 2017, from 1900 to 2100 hours.

During interviews with Inspector #625 on May 9, 2017, the Ward Clerk/Scheduler acknowledged that there was no RN in the building during the dates and times identified on the "Sign in Sheets" reviewed by the Inspector.

During an interview with the Executive Director (ED) on May 10, 2017, they acknowledged that there had been no RN in the building on April 16, 2017, from 0700 to 0900 hours; on April 26, 2017, from 0700 to 1900 hours; and on April 29, 2017 from 1900 to 2100 hours. The ED identified scheduling challenges as the reason for the lack of an RN in the building during those times. [s. 8. (3)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On a day in May 2017, Inspector #617 observed resident #006's assistive device as having debris and dust/dirt present on multiple surfaces.

On three subsequent days in May 2017, Inspector #625 observed debris and dust on resident #006's assistive device present on multiple surfaces.

During an interview with Inspector #625 on a specific date in May 2017, Personal Support Worker (PSW) #111 stated that assistive devices were to be cleaned on the night shift as per the schedule located in in the Night Shift Cleaning Schedule binder.

Inspector #625 reviewed the Night Shift Cleaning Schedule binder that indicated that staff were to initial in designated areas and forward completed sheets each week to the Director of Care (DOC). Resident #006's assistive device was scheduled to be cleaned on a particular day of the week and a review of the schedule from a specific date in April to a specific date in May 2017, identified that four out of six weeks, or 67 per cent, of resident #006's scheduled assistive device cleaning dates were not signed for.

On a specific date in May 2017, during an interview with Inspector #625, PSW #108 viewed resident #006's assistive device and acknowledged that it was soiled and that it did not look like it had been cleaned as signed for on a specific date in April 2017, as the debris present appeared to have gathered over time. The PSW lifted up a moveable surface and acknowledged that the debris could be removed by touch. The PSW identified that the staff on the night shift were required to follow the cleaning schedule and use appropriate cleaning supplies, as needed.

On a specific date in May 2017, RN #104 stated that the assistive device did not appear clean and that staff were supposed to use a disinfectant to clean residents' assistive devices on night shifts and sign that it had been completed. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

(a) On May 3, 2017, Inspector #625 observed disrepair to the walls, flooring and bathroom of a resident room.

On May 3 and 9, 2017, respectively, Inspectors #625 and #617 observed that the floor of the resident's room had areas that were cracked with portions missing near the bathroom door. The wall beside the closet was missing the entire wall length of the baseboard and the metal edging of the wall frame and drywall were exposed as paint had chipped off. The wall near the bathroom had three areas that each contained three screws and/or screw holes with gouges around them exposing the drywall. The bedroom area had multiple gouges and scrapes in the drywall and door. The toilet in this resident room had caulking missing around the base that exposed black debris/dirt and the sink counter top which was painted brown, displayed large areas worn off exposing the counter top.

Inspector #617 toured this resident room with the Environmental Services Manager (ESM) to review the areas of disrepair. The ESM acknowledged the disrepair to the doors, walls, flooring and bathroom in the room. The ESM indicated that the doors and flooring needed to be replaced, the walls needed to be patched and painted and the bathroom counter needed to be replaced.

(b) On May 3, 2017, Inspector #616 observed disrepair to the toilet in the bathroom of a resident room.

On May 3, and 9, 2017, respectively, Inspectors #616 and #617 observed the toilet bowl of the resident's bathroom to have a constant flow of water in the bowl which resulted in brown staining within the bowl.

Inspector #617 toured the bathroom of the resident's room with the ESM to review the disrepair. The ESM acknowledged that the bathroom toilet in this room was stained brown due to constant running of water in the bowl and had a crack in the base of the toilet which required immediate replacement.

(c) During the initial tour of the home, on May 2, 2017, Inspector #617 observed the following common areas in a state of disrepair:

(i) In common areas:
- black scuff marks on the walls between four resident rooms;
- the bottom left of the door frame at the entrance of a resident room had an approximately 5 centimeter (cm) piece of frame broken and sticking out; and
- a covered radiator along the entire length of the wall, in the resident common area beside exit doors, was missing one end cover piece while the other end piece was not attached.

Inspector #617 toured the common areas of that location with the ESM to review the areas of disrepair. The ESM acknowledged the following areas of disrepair to the Inspector:
- the hallway walls with scuff marks identified in between residents' rooms needed to be re-painted;
- the frame around a resident room needed to be replaced and re-painted; and
- one of the radiator cover end pieces needed to be attached and the other needed to be replaced.

(ii) In common areas:
- the tub room shower was out of order;
- the elevator door had several areas of scrapes where paint was missing including five areas measuring approximately 2.5 cm in length and two areas measuring approximately 10 cm in length;
- green flooring in the dining room had 15 circular gouges approximately 1 to 1.5 cm in diameter indented into the flooring which were brown;
- the flooring in the hallway beside the elevator had four areas of missing flooring exposing the layer underneath, two areas were approximately 2.5 cm in diameter and

two were 0.5 cm in diameter; and
- black scuff marks on the walls between a resident room and the exit doorway, between two residents' rooms, between a specific room and the entrance to the tub room, and between the clean utility room and a specific room.

In an interview with PSWs #108 and #116, they reported to the Inspector that the tub room shower had been out of order for the past year due to a hole in the floor of the shower stall that would leak water into the floor below it when used.

The Inspector toured the tub room shower with the ESM to review the areas of disrepair. The ESM acknowledged that the shower had been out of order for the past year.

Inspector #617 toured the common areas with the ESM to review the areas of disrepair. The ESM acknowledged the following areas of disrepair to the Inspector:
- the elevator door had several areas of scraped paint and required to be re-painted;
- the flooring had several holes in which the flooring needed to be replaced; and
- the walls in between resident rooms had several areas with scuff marks that required re-painting. [s. 15. (2) (c)]

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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was, at least quarterly, a documented reassessment of each resident’s drug regime.

On May 10, 2017, during a record review of resident #009's physician's orders, Inspector #617 identified that resident #009 did not have a current quarterly reassessment of their drug regime.

Inspector #617 reviewed resident #009's Medication Administration Record (MAR) for January, February, March, April, and May of 2017. Each one indicated that multiple registered staff had documented that they had administered multiple medications and a supplement to resident #009.

A review of resident #009's physician's orders for the administration of their medications during the months of January, February, March, April and May was identified in the "Physician's Order Review" signed by physician #117 on particular date in the fall of 2016. This "Physician's Order Review" authorized the administration of these medications for a specific three month period in 2016. The two "Physician's Order Reviews" authorizing the administration of these medications for a specific six month period in 2017 were missing.

On a particular date in May 2017, in an interview with Registered Practical Nurse (RPN) #105, they reported to the Inspector that resident #009's physician #117, had not attended the home for a particular length of time. Furthermore, the "Physician's Order Reviews" for resident #009 had not been signed and the administration of these medications for a specific six month period in 2017, had not been reviewed and authorized by the physician.

A review of the MediSystem Pharmacy policy titled “Prescribing-Medication Reviews - #03-01-30”, last reviewed on June 23, 2014, indicated that each resident’s medication orders ("Physician’s Order Reviews") were to be reviewed every three months for long-term care homes. The policy also identified that diets, treatments, restraints, physiotherapy and occupational therapy orders were to always be completed and reviewed at the time of the review.

During an interview with the ED, they reported to Inspector #617 that physician #117 had signed a contract with the home, identifying their services to the residents of the home under their care.

A review of the physician's contract listed their responsibilities which indicated that they were to review the resident's medications, treatments, and orders every three months.

Inspector #617 interviewed the DOC who reviewed physician #117's contract and confirmed that their responsibilities were to review the resident's medications, treatments, and orders every three months.

During an interview with Pharmacist #109, they confirmed to the Inspector that it was the responsibility of the registered staff to inform each physician of the home when the resident's three month "Physician's Order Review", which was compiled and sent to the home by MediSystem Pharmacy, needed to be reassessed and signed.

During an interview with RPN #106 and RN #104, they reported to the Inspector that several residents in the home had not had their "Physician's Order Review" signed for the current authorization period. They were not aware of the home's policy and their responsibility to ensure that the physician reviewed and signed the "Physician's Order Review" and were under the assumption that it was the Pharmacist's responsibility to do so.

A review of the unsigned "Physician's Order Reviews" indicated that a total of 13 residents were missing physician signatures authorizing the administration of the residents' medications for the period of April 1, to June 30, 2017, and 33 residents were missing physician signatures authorizing the administration of the residents' medications for the period of May 1, to July 31, 2017. In total, 46 residents, or 54 per cent of the residents in the home, did not have a current and valid prescription for administration of their medications that had been administered since either April 1 or May 1, 2017, and were currently being administered.

In an interview with the DOC, they confirmed to the Inspector that a "Physician Order Review" was a physician's order. The DOC further explained that a valid physician's order required the physician's signature to authorize the order for a three month period. They confirmed to the Inspector that the physician's order for the administration of medications to resident #009 was not valid for a specific six month period in 2017; and the unsigned "Physician's Order Reviews" found for 46 residents in the home were not

valid for the periods from April 1 to June 30, 2017, and May 1 to July 31, 2017. [s. 134. (c)]

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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector; O. Reg. 79/10, s. 213 (4).
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and O. Reg. 79/10, s. 213 (4).
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, had at least one year of experience working as a registered nurse in the long-term care sector.

During inspection #2017_633577_0004, Compliance Order #002 was issued pursuant to Ontario Regulation 79/10 s. 213 (4) (a) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, has at least one year of experience working as a registered nurse in the long-term care sector. The compliance due date was April 5, 2017.

On May 9 and 10, 2017, during interviews with Inspector #625, the ED stated that the home's current DOC was the employee in place when Compliance Order #002 was issued during inspection #2017_633577_0004. The ED stated that they could not confirm if the current DOC met all of the requirements outlined in the legislation, and specifically stated that they did not know if the DOC had at least one year of experience working as a registered nurse in the long-term care sector.

On May 9, 2017, during an interview with Inspector #625, the home's DOC acknowledged that they did not have at least one year of experience working as a registered nurse in the long-term care sector.

On February 1, 2017, Inspector #625 reviewed the DOC's employee file with a focus on qualifications for the DOC position. The file identified that the DOC had been hired effective a date in the winter of 2017, but did not indicate that the DOC had any experience working as an RN in the long-term care sector. [s. 213. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A Critical Incident System (CIS) report was submitted to the Director for a fall with injury that occurred in the winter of 2017, where resident #030 was discovered after having fallen by RN #112.

During an interview with Inspector #625 on a particular date in May 2017, resident #030 stated that they currently used specific equipment related to falls.

During observations of resident #030's room on two specific dates in May 2017, Inspector #625 observed the particular falls equipment present.

During an interview with RPN #114 on a particular date in May 2017, they stated to the Inspector that the resident utilized the falls equipment observed by the Inspector.

During an interview with PSW #113 on a date in May 2017, they stated to Inspector #625 that resident #030 used the previously observed falls equipment which would be listed in the resident's care plan. The PSW proceeded to show the Inspector the location of resident #030's care plan located in a binder at the nursing station.

On a date in May 2017, Inspector #625 reviewed resident #030's care plan located in the binder at the nursing station with a most recent revision dated on a particular day during the spring of 2017, which was accessed by PSWs, RPNs and RNs; and the care plan located on Point Click Care (PCC), with a most recent revision dated nine days after the date of the care plan in the binder, which was accessed by RNs and RPNs. Neither version of the care plan identified that the observed falls equipment was to be used for resident #030.

During an interview with Inspector #625 on a date in May 2017, RPN #115 checked the current care plan in PCC and the care plan located in the binder at the nursing station and acknowledged that the use of the observed falls equipment was not identified in either version of the care plan.

During an interview with Inspector #625 on May 10, 2017, the Director of Care (DOC) stated that falls equipment was used for resident #030, that it should have been included in the resident #030's care plan, but that it was not included in either version of the care plan that was in use. [s. 6. (1) (a)]

2. The licensee has 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.

A CIS report was submitted to the Director for an unwitnessed fall with injury that occurred on a particular date in the winter of 2017, where resident #030 was discovered after having fallen by RN #112.

During an interview with Inspector #625 on a particular date in May 2017, resident #030 stated that they used specific falls prevention equipment.

During observations of resident #030 and the resident's room on two specific dates in May 2017, Inspector #625 observed the falls prevention equipment present.

During an interview with PSW #113 on a particular date in May 2017, they stated to the

Inspector that resident #030 used the observed falls prevention equipment which would be listed in the resident's care plan located in a binder at the nursing station.

During an interview with RPN #114 on a particular date in May 2017, they stated to the Inspector that the resident utilized the observed falls prevention equipment.

On a particular date in May 2017, Inspector #625 reviewed resident #030's care plan located in the binder at the nursing station which had a revision dated from the spring of 2017. The care plan identified interventions under the focus of "risk for falls", including the observed falls prevention equipment.

On a particular date in May 2017, Inspector #625 reviewed resident #030's current care plan located on PCC which had a most recent revision dated on a specific date during the spring of 2017. The care plan identified interventions under the focus of "risk for falls" but did not identify that resident #030 used the observed falls prevention equipment.

During an interview with Inspector #625 on a particular date in May 2017, RPN #115 checked the current care plan located in PCC and acknowledged that the intervention related to the use of the observed falls prevention equipment had been removed from the current electronic care plan, but was located in the hard copy of the care plan. The RPN stated that the direction regarding resident #030's use of the falls prevention equipment was unclear for registered nursing staff who would refer to either care plan for direction.

During an interview with Inspector #625 on May 10, 2017, the DOC acknowledged that the falls prevention equipment should have been listed consistently in both the electronic and hard copy care plans that were in use. [s. 6. (1) (c)]

3. On a particular date in May 2017, during a staff interview with Inspector #625, resident #013 was identified as using a specific device to aid in elimination for a reason that did not meet specified criteria.

On a particular date in May 2017, Inspector #625 reviewed resident #013's health care record with a focus on the device used to aid in elimination and identified that:
- the order tab found in PCC listed a specific device used to aid in elimination, to be changed at a specific frequency on a specific recurring date that would not always coincide with the frequency listed;
- the current care plan indicated the resident used the device but did not indicate specific characteristics of the device or the frequency of changing the device;

- the electronic Treatment Administration Record (eTAR) for two consecutive months identified the specific device was to be changed at a specific frequency on a specific recurring date. The device change had not been signed for during the last scheduled recurring date and was next scheduled to be changed two days before the specific recurring date listed in the order tab and on the eTAR entry; and
- the most recent (but not current) "Physician's Order Review" dated on a particular date in the winter of 2017, indicated the device was to be changed at a specific frequency (that differed from the frequency listed in the order tab and eTAR) but did not list a specific recurring date.

A review of progress notes identified that there was no corresponding note regarding the last scheduled device change, which had not been signed for.

During an interview with RN #104 on a particular date in May 2017, they reviewed the order tab displayed in PCC with the Inspector, that indicated the device was to be changed at a specified frequency on a specific recurring date; the eTAR and found the change was listed to occur two days before the recurring specific date; and a doctor's order that indicated the device was to be changed at a different frequency than the specific recurring date listed in the eTAR. RN #104 stated that it was not clear when the device was to be changed and verified that the device change for the last scheduled time frame had not been documented on the eTAR.

During an interview with Inspector #625 on May 11, 2017, the DOC stated that, if written physician's orders indicated that a device was to be changed at a specified frequency, that the electronic order identified a different frequency as well as a specific recurring date, and the eTAR reflected that the device was to be changed on a different recurring date, the direction to the staff on when to change the device was not clear. The DOC also stated that staff were to document on the eTAR to indicate that the device had been changed. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On a particular date in May 2017, during a staff interview with Inspector #617, resident #005 was identified as using a device to aid in elimination for a reason that did not meet specified criteria.

On two specific dates in May 2017, Inspector #625 observed resident #005 with the

device in use.

On May 11, 2017, the Inspector reviewed resident #005's health care record including:
- physician's orders dated on a specific date in the spring of 2017. The order did not identify that the device was ordered;
- the current care plan that indicated that the resident had a medical condition and required the use of a different intervention for the condition, but did not identify that the device was in use for the condition;
- the eTAR that did not identify that the device was in use;
- the most recent "EO Bladder Continence Assessment" in PCC dated a specific date in the spring of 2016, that indicated the resident exhibited the medical condition and required the use of a different intervention for the condition than the device in use; and
- progress notes from a specific date in the spring of 2017 that identified that the resident used the device.

During an interview with Inspector #625 on a particular date in May 2017, PSW #108 stated that they knew resident #005 used the device by visually observing it and knew how to provide care to the resident related to their use of the device from previous experience. The PSW stated that there was no place to document specific characteristics of the resident's use of the device and that they did not know if the care plan identified that the resident used the device as they had not looked at it.

During an interview with Inspector #625 on a particular date in May 2017, RPN #105 stated that the use of the device for resident #005 should be identified in the eTAR but that it was not there, and that they could not tell from the progress notes or eTAR how long the resident had used the device. The RPN stated that they needed to visually confirm that the resident used the device as the electronic chart did not identify when it was initiated, but that the use of the device should have been identified in the eTAR and care plan.

During interviews with Inspector #625 on a specific date in May 2017, both RPN #105 and RPN #106 stated that, after a specific event involving resident #005, the device had been initiated, and that a "Bladder Continence Assessment" should have been completed in PCC to assess the change in the resident's status.

During an interview with Inspector #625 on a particular date in May 2017, RN #104 stated that resident #005 had the device in place since a specific event involving the resident, and acknowledged that there was no physician's order for the device. The RN

stated that the current care plan and eTAR did not identify that the device was in use, but that the care the resident required with respect to the use of the device should have been identified in the care plan and eTAR, and that a physician's order should have been obtained.

During an interview with the DOC on May 11, 2017, they stated to the Inspector that residents using the device should have a physician's order in place, that direction to the staff related to the characteristics of the device, frequency of device changes, any required monitoring, and that an assessment should be completed as to the reason for the device use. [s. 6. (2)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

A CIS report was submitted to the Director for a fall with injury that occurred on a particular date in the winter of 2017, where resident #030 was discovered after having fallen by RN #112. The report was amended 23 days after it was submitted, to include the use of a specific personal assistance services device (PASD) as an immediate action taken to prevent recurrence.

During an interview with Inspector #625 on a particular date in May 2017, resident #030 stated that they used the specific PASD. The resident demonstrated to the Inspector that they could remove and apply the PASD independently.

During observations of resident #030 on two specific dates in May 2017, Inspector #625 observed the PASD applied.

During an interview with PSW #113 on a particular date in May 2017, they stated to the Inspector that resident #030 used a PASD which staff had to remind the resident to engage. The PSW stated that the use of the PASD as an intervention would be listed in the resident's care plan located in a binder at the nursing station.

During an interview with RPN #114 on a particular date in May 2017, they stated to the Inspector that the resident utilized a specific PASD.

On May 10, 2017, Inspector #625 reviewed resident #030's care plan located in the binder at the nursing station which had a revision dated a specific date in the spring of

April 2017. The care plan identified interventions under the focus of "risk for falls" including that the resident was to have an additional component added to the PASD to discourage the resident from disengaging it.

On May 10, 2017, Inspector #625 reviewed resident #030's current care plan located on PCC which had a most recent revision dated nine days after the date identified on the care plan located at the nursing station. The care plan identified interventions under the focus of "risk for falls" including that the resident was to have an additional component added to the PASD to discourage the resident from disengaging it.

During an interview with Inspector #625 on a particular date in May 2017, RPN #115 stated that the resident was able to disengage the PASD, even when the additional component had been in use, so staff had removed the additional component and were no longer using it. The RPN indicated that the additional component had not been used to date during the month of May.

During an interview with Inspector #625 on May 10, 2017, the DOC acknowledged that resident #030's plan of care had not been revised to reflect the changes that occurred with respect to the use of the PASD's additional component. [s. 6. (10) (c)]

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 that ensures that:
- that there is a written plan of care for resident #030 and for each resident that sets out the planned care for the resident;
- that the written plans of care for residents #030 and #013 and for each resident sets out clear directions to staff and others who provide direct care to the resident;
- the care set out in the plan of care for resident #005 and for each resident is based on an assessment of the resident and the needs and preferences of that resident; and
- resident #030 and each resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that was in place to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #621 reviewed a CIS report that was submitted to the Director on a particular date in the winter of 2017, for an alleged incident of resident to resident abuse reported by resident #019 to RPN #107 the previous day. The report identified that resident #019 informed the RPN that resident #020 had abused them.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02", last updated January 2016, indicated that all staff who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect were to report it immediately to the Administrator/designate/reporting manager or, if unavailable, to the most senior supervisor on shift at that time. The policy also identified that the Administrator/designate department manager/supervisor was to immediately initiate a dignified and respectful investigation of the alleged, suspected or witnessed abuse, notify police authorities as per jurisdictional legislative requirements and that the Administrator had the authority to place an employee on a leave of absence with pay pending the results of the investigation.

During an interview with RPN #107 on a particular date in May 2017, they identified to Inspector #621 that they were the staff person on duty whom resident #019 spoke with on a particular date in the winter of 2017, and reported an alleged incident of abuse. RPN #107 further indicated that they were responsible to immediately notify the manager on-call to report the incident on the date the resident reported the alleged abuse, but did not do so.

During an interview with the DOC on May 9, 2017, they identified to the Inspector that it was their expectation that when an incident of suspected, witnessed or alleged abuse occurred after hours, that registered staff would contact the manager on-call and notify them. The DOC identified that although they were not the manager who was on-call that evening, no other manager in the home had been contacted on the particular date in the winter of 2017 regarding the incident. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that, without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #621 reviewed a CIS report that was submitted to the Director on a particular

date in the winter of 2017, for an alleged incident of resident to resident abuse reported by resident #019 to RPN #107 on a particular date in the winter of 2017. The report identified that resident #019 informed the RPN that resident #020 had abused them.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02" included "Appendix 1 - Jurisdictional Reporting Requirements", last updated January 2016. The appendix, referenced the LTCHA, 2007, s. 24. (1) and indicated that any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee of staff that resulted in harm or a risk of harm to the resident had occurred or may have occurred, was to immediately report the suspicion and the information upon which it was based to the Director of the Ministry of Health and Long-Term Care. The appendix listed that reporting to the Director was to occur online via the Critical Incident System, or after hours by pager.

During an interview with RPN #107 on a particular date in May 2017, they identified to Inspector #621 that they were the staff person on duty whom resident #019 spoke with on the particular date in the winter of 2017, and reported an alleged incident of abuse. RPN #107 further indicated that they were responsible to immediately contact the MOHLTC after-hours pager to report the incident on the particular date in the winter of 2017, but did not do so, which resulted in failure to meet the immediate reporting requirement.

During an interview with the DOC on May 9, 2017, they identified to the Inspector that it was their expectation that when an incident of suspected, witnessed or alleged abuse occurred after hours, that registered staff would contact the MOHLTC after-hours pager to report the incident and obtain an incident number for the report. The DOC confirmed that the Director had not been notified of the incident by the home until the evening following the date the resident reported the allegation to the RPN, and that this did not meet the reporting requirement. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #617 reviewed a CIS report that was submitted to the Director on a particular date in the winter of 2017, related to an incident that caused injury to resident #007 for

which the resident was taken to hospital and resulted in a significant change to their health status. The report indicated that five days earlier, resident #007 reported to RPN #106 that a PSW provided them with improper care which resulted in an injury to the resident. The resident was not able to identify the exact time it occurred or the PSW who provided the improper care. The home reported the incident to the Director five days after the incident had occurred.

A review of the home's investigation notes by Inspector #617 identified that, five days before the submission of the CIS report, RPN #106 notified the on-call Program Manager, that an incident regarding improper care of resident #007 resulting in an injury had occurred.

In an interview with RPN #106, they clarified to the Inspector that resident #007's report to them of the improper care resulting in an injury was an incident that required immediate reporting to the Director. The RPN further explained that it was the responsibility of the registered staff to report this incident to the Director immediately. They confirmed to the Inspector that on the date that they were made aware of the incident, they did not notify the Director.

A review of the home’s policy titled “Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02” included “Appendix 1 - Jurisdictional Reporting Requirements”, last updated January 2016. The appendix, referenced the LTCHA, 2007, s. 24. (1) and indicated that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was to immediately report the suspicion and the information upon which it was based to the Director of the Ministry of Health and Long-Term Care.

On May 11, 2017, Inspector #617 interviewed both the ED and DOC who both confirmed that resident #007's report to RPN #106 should have been immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director:
- improper or incompetent treatment or care of resident #007, or any other resident in the home, that resulted in harm or a risk of harm to the resident; and
- abuse of resident #019, or any other resident in the home, by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff only apply a physical device that has been ordered or approved by a physician or registered nurse in the extended class.

On a particular date in May 2017, Inspector #625 observed resident #009 with a safety device engaged, functioning as a potential restraint.

On two particular dates in May 2017, Inspectors #625 and #617 observed resident #009 with a safety device engaged. On one of the dates in May 2017, Inspector #617 attempted to interview resident #009 but was not able to due to characteristics exhibited by the resident.

A review of resident #009's health care record by Inspector #617 identified that the resident was at a risk of falling and required the use of a safety device engaged as a restraint to prevent injury.

In an interview with PSW #116, they confirmed to Inspector #617 that resident #009's use of the safety device was a restraint to prevent them from injury due to characteristics of the resident, the resident's falls history and that they were at risk for falls.

A review by Inspector #617 of the home's policy titled "Restraints-Physical/Mechanical - 08-10-02" last revised May 2010, indicated that the need for restraint use required reassessment quarterly with a renewed physician's order.

Inspector #617 reviewed resident #009's physician's orders for the use of the safety device which was identified in the "Physician's Order Review" signed by physician #117 on a date in the fall of 2016. This "Physician's Order Review" authorized the use of the restraint for a three month period in 2016. The two "Physician's Order Reviews" authorizing the use of the restraint for a six month period in 2017 were missing.

On a date in May 2017, in an interview with RPN #105, they reported to Inspector #617 that resident #009's physician #117, had not signed the "Physician's Order Reviews" for resident #009, and the use of the restraint use for the six month period in 2017 had not been authorized.

Inspector #617 interviewed the DOC who confirmed that a "Physician Order Review" was a physician's order. They further explained that a valid physician's order required the physician's signature to authorize the order for a three month period. The DOC reviewed resident #009's physician's order reviews and confirmed to the Inspector that the physician's order for the use of the restraining was not valid for the six month period in 2017. [s. 110. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the following requirement is met where resident #009, or any other resident, is being restrained by a physical device under section 31 of the Act: that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #9: 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. (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 has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed.

A review by Inspector #617 of the home's medication incident reports indicated that, in 2016, five incidents were reported to the DOC. Of the five incidents, four, or 80 per cent, were not followed up on by the DOC and had no review or analysis completed.

According to the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10, the definition of a medication incident is a preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distributing of a drug, or the transcribing of a prescription, and includes:
- an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
- a near miss event where an incident does not reach a resident but had it done so, harm, injury, or death could have resulted.

In an interview with the DOC they confirmed that the DOC was responsible to review and analyze the incidents to ensure resident safety and prevent any further occurrences. The DOC reviewed the medication incident reports with the Inspector and confirmed that the review and analysis was not completed for four of the incidents. [s. 135. (2)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview with Inspector #617, the DOC confirmed that a total of five medication incidents had occurred in 2016. The DOC reported to the Inspector that all medication incidents were to be reviewed at quarterly Professional Advisory Committee (PAC) meetings.

A review of the home's PAC meeting minutes indicated that an interdisciplinary team consisting of the physician, Pharmacist, DOC, Social Worker, Registered Dietitian, Environmental Services Manager, public health representative, Resident Assessment Instrument (RAI) Coordinator, Program Manager, Physiotherapist and registered staff reviewed resident care concerns and quality management.

A review of the home's PAC meeting minutes held on January 27, 2016, April 13, 2016, October 12, 2016, and January 26, 2017, identified that the minutes did not include a review of the five medication incidents that had occurred and were reported to the DOC.

In an interview with the DOC they confirmed to the Inspector that medication incidents had not been reviewed at PAC to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (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 that ensures that all medication incidents and adverse drug reactions are documented, reviewed and analyzed; and that 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, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required posted information identified in the Long-Term Care Homes Act, 2007, for the purposes of s. 79 (1) and (2), specifically copies of the inspection reports from the past two years for the long-term care home, were posted in the home at the time of inspection.

On May 2, 3, 4 and 9, 2017, Inspector #617 toured the home and observed that the following copies of the inspection reports from the past two years for the long-term care home were not posted in the home at the time of inspection:
- Resident Quality Inspection #2015_246196_0011 dated July 6, 2015; and
- Complaint Inspection #2016_246196_0009 dated July 12, 2016.

On May 9, 2017, during an interview with the ED, they confirmed to the Inspector that the above required inspection reports were not posted in the home at the time of inspection. [s. 79. (3) (k)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident, were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that resulted in physical injury or pain to the resident or that caused distress to the resident that was potentially detrimental to the resident's health or well-being.

Inspector #621 reviewed a CIS report that was submitted to the Director on a date in the winter of 2017, for an alleged incident of resident to resident abuse reported by resident #019 to RPN #107 the previous day. Resident #019 informed the RPN that resident #020 had abused them. The report also identified that the substitute decision maker (SDM) for resident #019 was not notified of the incident until the evening after the date the allegation was reported to the RPN.

During an interview with RPN #107 on a date in May 2017, they identified to Inspector #621 that they were the staff person which resident #019 reported an allegation of abuse to on a particular date in the winter of 2017. RPN #107 also reported that as part of their reporting responsibilities, they had not contacted resident #019's SDM until the next day.

During an interview with the DOC on May 9, 2017, they identified to the Inspector that it was their expectation that as soon as registered staff become aware of an alleged, suspected or witnessed incident of abuse, that the SDM for resident #019 was to be notified. On review of the CIS report, they confirmed to the Inspector that RPN #107 was aware of the alleged incident of abuse on the a particular date in the winter of 2017, and that the RPN did not follow the home's reporting process and, consequently, the SDM for resident #019 was not notified until a day after the allegation of abuse was made. [s. 97. (1) (a)]

Issued on this 9th day of August, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHERINE BARCA (625), JENNIFER KOSS (616), JULIE KUORIKOSKI (621), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2017_652625_0010
Log No. / No de registre :	005873-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 3, 2017
Licensee / Titulaire de permis :	CVH (No.2) LP c/o Southbridge Care Homes, 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	BIRCHWOOD TERRACE 237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Wendy Sarfi

To CVH (No.2) LP, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_633577_0002, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During inspection #2017_633577_0002 Compliance Order #001 was issued pursuant to the Long-Term Care Homes Act, 2007, s. 8. (3). The licensee was ordered to ensure that there was at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, except as provided for in the regulations, with a compliance date of March 22, 2017.

Inspector #625 reviewed the home's "Sign in Sheets" from March 22, 2017, to May 8, 2017, and identified that there had been no registered nurse (RN) on site in the home on Sunday, April 16, 2017, from 0700 to 0900 hours; on Wednesday, April 26, 2017, from 0700 to1900 hours; and on Saturday, April 29, 2017, from 1900 to 2100 hours.

During interviews with Inspector #625 on May 9, 2017, the Ward Clerk/Scheduler acknowledged that there was no RN in the building during the dates and times identified on the "Sign in Sheets" reviewed by the Inspector.

During an interview with the Executive Director (ED) on May 10, 2017, they acknowledged that there had been no RN in the building on April 16, 2017, from 0700 to 0900 hours; on April 26, 2017, from 0700 to 1900 hours; and on April 29, 2017 from 1900 to 2100 hours. The ED identified scheduling challenges as the reason for the lack of an RN in the building during those times.

Previous non-compliance related to this legislation, LTCHA 2007, S.O. 2007, c. 8, s. 8. (3) was issued during the following inspections:
- a Written Notification/Compliance Order issued from inspection #2017_633577_0002 on March 8, 2017;
- a Written Notification/Voluntary Plan of Correction issued from inspection #2016_246196_0009 on October 18, 2016; and
- a Written Notification/Voluntary Plan of Correction issued from inspection #2016_339617_0004 on March 10, 2016.

The decision to issue this Compliance Order was based on the scope which was widespread, the severity which indicated minimal harm or potential for actual harm to occur and the home's compliance history, which included the licensee's continued non-compliance with this area of the legislation. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee is specifically ordered to address the identified disrepair in the following areas:
- the floor, walls, baseboards, door, door frame, toilet and bathroom counter top in a resident room;
- the toilet in a resident room;
- the walls, door frame and radiator in a common area; and
- the tub room shower, elevator door, flooring and walls in a common area.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

(a) On May 3, 2017, Inspector #625 observed disrepair to the walls, flooring and bathroom of a resident room.

On May 3 and 9, 2017, respectively, Inspectors #625 and #617 observed that the floor of the resident's room had areas that were cracked with portions missing near the bathroom door. The wall beside the closet was missing the entire wall length of the baseboard and the metal edging of the wall frame and drywall were exposed as paint had chipped off. The wall near the bathroom had

three areas that each contained three screws and/or screw holes with gouges around them exposing the drywall. The bedroom area had multiple gouges and scrapes in the drywall and door. The toilet in this resident room had caulking missing around the base that exposed black debris/dirt and the sink counter top which was painted brown, displayed large areas worn off exposing the counter top.

Inspector #617 toured this resident room with the Environmental Services Manager (ESM) to review the areas of disrepair. The ESM acknowledged the disrepair to the doors, walls, flooring and bathroom in the room. The ESM indicated that the doors and flooring needed to be replaced, the walls needed to be patched and painted and the bathroom counter needed to be replaced.

(b) On May 3, 2017, Inspector #616 observed disrepair to the toilet in the bathroom of a resident room.

On May 3, and 9, 2017, respectively, Inspectors #616 and #617 observed the toilet bowl of the resident's bathroom to have a constant flow of water in the bowl which resulted in brown staining within the bowl.

Inspector #617 toured the bathroom of the resident's room with the ESM to review the disrepair. The ESM acknowledged that the bathroom toilet in this room was stained brown due to constant running of water in the bowl and had a crack in the base of the toilet which required immediate replacement.

(c) During the initial tour of the home, on May 2, 2017, Inspector #617 observed the following common areas in a state of disrepair:

(i) In common areas:
- black scuff marks on the walls between four resident rooms;
- the bottom left of the door frame at the entrance of a resident room had an approximately 5 centimeter (cm) piece of frame broken and sticking out; and
- a covered radiator along the entire length of the wall, in the resident common area beside exit doors, was missing one end cover piece while the other end piece was not attached.

Inspector #617 toured the common areas of that location with the ESM to review the areas of disrepair. The ESM acknowledged the following areas of disrepair to the Inspector:

- the hallway walls with scuff marks identified in between residents' rooms needed to be re-painted;
- the frame around a resident room needed to be replaced and re-painted; and
- one of the radiator cover end pieces needed to be attached and the other needed to be replaced.

(ii) In common areas:
- the tub room shower was out of order;
- the elevator door had several areas of scrapes where paint was missing including five areas measuring approximately 2.5 cm in length and two areas measuring approximately 10 cm in length;
- green flooring in the dining room had 15 circular gouges approximately 1 to 1.5 cm in diameter indented into the flooring which were brown;
- the flooring in the hallway beside the elevator had four areas of missing flooring exposing the layer underneath, two areas were approximately 2.5 cm in diameter and two were 0.5 cm in diameter; and
- black scuff marks on the walls between a resident room and the exit doorway, between two residents' rooms, between a specific room and the entrance to the tub room, and between the clean utility room and a specific room.

In an interview with PSWs #108 and #116, they reported to the Inspector that the tub room shower had been out of order for the past year due to a hole in the floor of the shower stall that would leak water into the floor below it when used.

The Inspector toured the tub room shower with the ESM to review the areas of disrepair. The ESM acknowledged that the shower had been out of order for the past year.

Inspector #617 toured the common areas with the ESM to review the areas of disrepair. The ESM acknowledged the following areas of disrepair to the Inspector:
- the elevator door had several areas of scraped paint and required to be re-painted;
- the flooring had several holes in which the flooring needed to be replaced; and
- the walls in between resident rooms had several areas with scuff marks that required re-painting.

Previous non-compliance related to this legislation, LTCHA 2007, S.O. 2007, c. 8, s. 15 (2) (c) was issued during the following inspections:

- a Written Notification/Voluntary Plan of Correction issued from Inspection #2016_512196_0015 on January 10, 2017; and
- a Written Notification/Voluntary Plan of Correction issued from Inspection #2014_211106_0014 on January 21, 2015.

The decision to issue this Compliance Order was based on the scope which demonstrated a pattern of occurrence, the severity which indicated minimal harm or potential for actual harm to occur and the home's compliance history, which included previous non-compliance with this area of the legislation. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 02, 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. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall ensure that there is, at least quarterly, a documented reassessment of each resident's drug regime.

The licensee is specifically ordered to:
- have a member of the registered nursing staff conduct an audit of resident #009's and every resident's health care record in the home to determine which residents do not have a current quarterly documented reassessment of their drug regimes;
- ensure the quarterly, documented reassessments of each resident's drug regimes are completed so that all residents in the home have current orders for the drugs they are administered;
- maintain documentation that includes each resident's name, the date their chart is audited, the results of the audit (including the date that the resident's quarterly assessment was overdue, if applicable), the name and classification of the member(s) of the registered nursing staff who conduct the audit, the corrective action taken to ensure the assessments are completed and the date (s) that each assessment is completed; and
- develop and implement a monitoring process to ensure that each resident in the home has, at least quarterly, a documented reassessment of their drug regime.

Grounds / Motifs :

1. The licensee has failed to ensure that there was, at least quarterly, a documented reassessment of each resident's drug regime.

On May 10, 2017, during a record review of resident #009's physician's orders, Inspector #617 identified that resident #009 did not have a current quarterly reassessment of their drug regime.

Inspector #617 reviewed resident #009's Medication Administration Record (MAR) for January, February, March, April, and May of 2017. Each one indicated that multiple registered staff had documented that they had administered multiple medications and a supplement to resident #009.

A review of resident #009's physician's orders for the administration of their medications during the months of January, February, March, April and May was identified in the "Physician's Order Review" signed by physician #117 on particular date in the fall of 2016. This "Physician's Order Review" authorized the administration of these medications for a specific three month period in 2016.

The two "Physician's Order Reviews" authorizing the administration of these medications for a specific six month period in 2017 were missing.

On a particular date in May 2017, in an interview with Registered Practical Nurse (RPN) #105, they reported to the Inspector that resident #009's physician #117, had not attended the home for a particular length of time. Furthermore, the "Physician's Order Reviews" for resident #009 had not been signed and the administration of these medications for a specific six month period in 2017, had not been reviewed and authorized by the physician.

A review of the MediSystem Pharmacy policy titled “Prescribing-Medication Reviews - #03-01-30”, last reviewed on June 23, 2014, indicated that each resident’s medication orders ("Physician’s Order Reviews") were to be reviewed every three months for long-term care homes. The policy also identified that diets, treatments, restraints, physiotherapy and occupational therapy orders were to always be completed and reviewed at the time of the review.

During an interview with the ED, they reported to Inspector #617 that physician #117 had signed a contract with the home, identifying their services to the residents of the home under their care.

A review of the physician's contract listed their responsibilities which indicated that they were to review the resident's medications, treatments, and orders every three months.

Inspector #617 interviewed the DOC who reviewed physician #117's contract and confirmed that their responsibilities were to review the resident’s medications, treatments, and orders every three months.

During an interview with Pharmacist #109, they confirmed to the Inspector that it was the responsibility of the registered staff to inform each physician of the home when the resident’s three month "Physician’s Order Review", which was compiled and sent to the home by MediSystem Pharmacy, needed to be reassessed and signed.

During an interview with RPN #106 and RN #104, they reported to the Inspector that several residents in the home had not had their "Physician’s Order Review" signed for the current authorization period. They were not aware of the home’s policy and their responsibility to ensure that the physician reviewed and signed

the "Physician's Order Review" and were under the assumption that it was the Pharmacist's responsibility to do so.

A review of the unsigned "Physician's Order Reviews" indicated that a total of 13 residents were missing physician signatures authorizing the administration of the residents' medications for the period of April 1, to June 30, 2017, and 33 residents were missing physician signatures authorizing the administration of the residents' medications for the period of May 1, to July 31, 2017. In total, 46 residents, or 54 per cent of the residents in the home, did not have a current and valid prescription for administration of their medications that had been administered since either April 1 or May 1, 2017, and were currently being administered.

In an interview with the DOC, they confirmed to the Inspector that a "Physician Order Review" was a physician's order. The DOC further explained that a valid physician's order required the physician's signature to authorize the order for a three month period. They confirmed to the Inspector that the physician's order for the administration of medications to resident #009 was not valid for a specific six month period in 2017; and the unsigned "Physician's Order Reviews" found for 46 residents in the home were not valid for the periods from April 1 to June 30, 2017, and May 1 to July 31, 2017.

The decision to issue this Compliance Order was based on the severity which indicated a potential for actual harm and, although the home does not have a compliance history previously issued pursuant to this area of the legislation, the scope demonstrated a pattern of occurrence. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 2017

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2017_633577_0004, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector;
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Order / Ordre :

The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of Ontario Regulation 79/10, r. 213 (4) has at least one year of experience working as a registered nurse in the long-term care sector.

Grounds / Motifs :

1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, had at least one year of experience working as a registered nurse in the long-term care sector.

During inspection #2017_633577_0004, Compliance Order #002 was issued pursuant to Ontario Regulation 79/10 s. 213 (4) (a) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, has at least one year of experience working as a registered nurse in the long-term care sector. The compliance due date was April 5, 2017.

On May 9 and 10, 2017, during interviews with Inspector #625, the ED stated that the home's current DOC was the employee in place when Compliance Order #002 was issued during inspection #2017_633577_0004. The ED stated that they could not confirm if the current DOC met all of the requirements outlined in the legislation, and specifically stated that they did not know if the DOC had at least one year of experience working as a registered nurse in the long-term care sector.

On May 9, 2017, during an interview with Inspector #625, the home's DOC acknowledged that they did not have at least one year of experience working as a registered nurse in the long-term care sector.

On February 1, 2017, Inspector #625 reviewed the DOC's employee file with a focus on qualifications for the DOC position. The file identified that the DOC had been hired effective a date in the winter of 2017, but did not indicate that the DOC had any experience working as an RN in the long-term care sector.

Previous non-compliance related to this legislation, Ontario Regulation 79/10, r. 213 (4), was issued during inspection #2017_633577_0004 when a Written Notification/Compliance Order was issued on March 8, 2017.

The decision to issue this Compliance Order was based on the scope which was widespread, the severity which indicated minimal harm or potential for actual harm to occur and the home's compliance history, which includes the licensee continued non-compliance with this area of the legislation. (625)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 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 or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Katherine Barca

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