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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 9, 2018	2018_728696_0008	025431-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

ZINNIA SHARMA (696), FARAH_ KHAN (695), HEATHER PRESTON (640)

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): September 18, 19, 20, 21, 24, 25, 26, 27, 28, October 1, 2, 3, and 4, 2018.

During the course of the inspection, the following Critical Incident intakes were inspected:

Intake #023631-17 related to alleged resident to resident sexual abuse.
Intake #027048-17 related to alleged resident to resident sexual abuse.
Intake #002237-18 related to unknown injury.

Intake #014491-18 related to resident to resident physical aggression.
Intake #015231-18 related to fall with injury.
Intake #016657-18 related to improper transfer of the resident.
Intake #020625-18 related to staff to resident allegation of physical abuse.
Intake #020866-18 related to resident to resident physical aggression.
Intake #026163-18 related to staff to resident allegation of abuse.
Intake #026405-18 related to staff to resident allegation of abuse.

During the course of the inspection, the following Complaint intakes were inspected:
Intake #029065-17 related to concerns about care.
Intake #006004-18 related to responsive behaviours.
Intake #007603-18 related to responsive behaviours.
Intake #020883-18 related to plan of care, medications, and bed rails.

During the course of the inspection, the following follow-up to Compliance Order was conducted:
Intake #025534-18 related to prevention of abuse of residents Compliance Order #001 issued under Inspection #2018_539120_0015.

During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, policies and procedures and meeting minutes, observed housekeeping practices and observed infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), housekeepers, recreation aides, registered practical nurses (RPN), registered nurses (RN), Behavioural Support Ontario (BSO) RPN, Environmental Services Manager (ESM), Maintenance Manager, Program Manager, MDS/PCC Coordinator, Food Services Manager (FSM), Social Service Worker (SSW), the Acting Director of Care (DOC), and the Administrator.

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **13 WN(s)**
- **7 VPC(s)**
- **2 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	Légende 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 has failed to ensure that residents were protected from abuse by anyone

and free from neglect by the licensee or staff in the home.

A. For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

During stage one of the Resident Quality Inspection (RQI), a resident reported to the Long-Term Care Homes (LTCH) Inspector that a particular staff member had been rude to them and were making degrading comments about them.

The LTCH Inspector reported the abuse to a staff member. The resident explained to the staff member that the degrading comments were made regularly and they had not reported it because they were afraid of facing retaliation.

In an interview with RPN #117, the RPN indicated that talking down to a resident or saying negative things about them would be considered abuse.

The home's policy, "Zero Tolerance of Resident Abuse and Neglect Program," included in its definition of verbal abuse, comments that diminish a resident's sense of well-being, dignity or self-worth. The policy indicated that there was a zero tolerance for abuse and neglect and that any form of abuse, whether deliberate acts or negligence, would not be tolerated.

In an interview with the Administrator, they acknowledged that based on interviews with the resident and co-staff, it was determined that verbal abuse did occur.

The licensee has failed to ensure that the resident was protected from verbal abuse by anyone. (695)

B. A Critical Incident (CI) report was submitted by the home to Ministry of Health and Long Term Care (MOHLTC) stating that a staff member observed resident #007 exhibiting inappropriate behaviour towards resident #031.

The clinical record for resident #031 was reviewed. It was documented that on a particular date a registered staff observed resident #007 exhibiting inappropriate behaviour towards resident #031. There was no documentation to indicate that

behaviour was consensual in nature.

The home's investigation indicated that interaction between the two residents was non-consensual in nature.

During an interview with RPN #134, they said that resident #007 had exhibited inappropriate behaviour towards resident #031.

The licensee has failed to ensure that resident #031 was protected from abuse by resident #007. [s. 19. (1)]

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at

least weekly by a member of the registered nursing staff, if clinically indicated.

A. During stage one of the RQI, resident #015 was triggered for skin impairment.

The LTCH Inspector reviewed the clinical record for resident #015 and found that the resident had acquired a new area of altered skin integrity on a specific date.

The home's policy "Skin and Wound Program: Wound Care Management", directed registered staff to re-assess areas of altered skin integrity on a weekly basis.

The LTCH Inspector reviewed resident #015's clinical record which revealed that there were two weekly skin assessments that were not completed for the area of altered skin integrity. There was no other documentation to indicate that staff had completed a weekly skin assessment for those two weeks.

During an interview with Registered Nurse (RN) #137, they stated that after a new area of altered skin integrity was identified registered staff were expected to do a weekly skin assessment until the skin issue had been resolved. The LTCH Inspector and the RN reviewed the weekly skin assessment records of the resident and they acknowledged that the registered staff did not complete any weekly skin assessments for resident #015's altered skin integrity for those two weeks. (696)

B. Resident #029 required assistance from staff with activities of daily living and were at moderate risk of altered skin integrity.

On a specific date, the resident was identified to have a new area of altered skin integrity. On a different date, they were identified with another area of altered skin integrity.

The LTCH Inspector reviewed the clinical record of resident #029 and found the weekly assessments of both the areas of altered skin integrity were not completed as required. Both the areas of altered skin integrity were included in the one tool, however, only one set of notes was documented on the tool. On a specific date, neither of the two areas of altered skin integrity were assessed.

During an interview with RPN #135 and the DOC, they both told the LTCH Inspector that weekly skin assessments should be conducted on the altered skin integrity until they had healed. They both stated it was an expectation that each area of altered skin integrity be assessed using an individual assessment instrument.

RPN #135 acknowledged the home failed to complete weekly assessments for the areas of altered skin integrity.

C. Resident #009 was assessed to require assistance with all activities of daily living and was at moderate risk of altered skin integrity.

On a specific date, the resident was identified with altered skin integrity.

The LTCH Inspector reviewed the clinical record of resident #009. On three occasions out of a required 24, the weekly wound assessments were not completed.

During an interview with RPN #109, they told the LTCH Inspector the resident acquired the altered skin integrity on a particular date and it never fully healed. They stated that it was expected that weekly wound assessments would be conducted on the altered skin integrity until they had healed.

RPN #109 acknowledged the home failed to complete all weekly assessments for the altered skin integrity.

The home has failed to ensure that resident #015, #029, and #009 who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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. 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 fall prevention, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

A CI Report was reviewed by the LTCH Inspector regarding resident #027 who sustained an injury after an unwitnessed fall.

The LTCH Inspector interviewed the resident who stated they had an unwitnessed fall and did not recall hitting their head at the time.

The home's policy "Falls Prevention and Management Program", directed that when a resident had an unwitnessed fall, they were to initiate a Clinical Monitoring Record, the home's neurological assessment instrument.

During an interview with RPN #117 they stated it was an expectation that when a resident had an unwitnessed fall that a Clinical Monitoring Record be initiated. They told the LTCH Inspector this was the home's neurological assessment tool.

The LTCH Inspector reviewed the resident's clinical record which identified the clinically appropriate fall assessment was completed immediately following the fall. However, there were no Clinical Monitoring Records, which included the neurological assessment, located in the clinical record. The LTCH Inspector and RPN #117 reviewed the clinical record and the RPN confirmed the required Clinical Monitoring Record was not included in the assessments for resident #027.

RPN #117 acknowledged the licensee failed to ensure that the fall prevention policy was complied with for resident #027. [s. 8. (1) (a),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 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 is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received fingernail care, including the cutting of fingernails.

During Stage one of the RQI, resident #013 was observed with improper fingernail care.

During a family interview, they stated that resident #013's fingernails were often unkempt. They would bring in their own clippers and cut the fingernails themselves. They stated they kept reminding staff but the nails often remained in the same condition.

On two specific dates, the resident was observed to have long, uneven fingernails with dark debris underneath.

Resident #013's plan of care directed staff to clean, cut and file the resident's fingernails and toenails at each bath day.

The home's policy "Daily Personal Care and Grooming", directed staff to provide individualized care as documented on the care plan.

During an interview with PSW #105, they stated that it was an expectation that during the bath/shower, that both finger and toe nails were to be cleaned and trimmed unless otherwise directed.

During an interview with PSW #108, they stated the resident was showered on the evening shift. They had not trimmed the resident's fingernails for over a month as they believed that an outside source was looking after the fingernails.

RPN #112 confirmed that resident #013 did not receive proper fingernail care. [s. 35. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee of a long-term care home must ensure that each resident of the home receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CI report was submitted by the home related to an improper transfer of resident #020, resulting in an injury.

Resident #020 had medical conditions. They were assessed to require total assistance of two persons for transfers.

On a specific date, it was noted that resident #020 had an injury.

The LTCH Inspector reviewed the resident's clinical record. The plan of care directed staff to use a mechanical lift for all transfers and that two persons were required for all aspects of the transfer.

The home's policy "Mechanical Lifts Procedure", directed staff to use two persons at all times and for all actions related to the use of the mechanical lift.

During an interview, RPNs #130 and #131 and PSW #105, told the LTCH Inspector it was an expectation that two persons assisted with the use of the mechanical lift from beginning to end.

During an interview with RPN #131, they told the LTCH Inspector they had participated in the interviewing of several staff. At the end of the process, PSW #125 admitted to using the mechanical lift during a transfer of resident #020 by themselves.

The licensee failed to ensure that resident #020 was transferred safely by staff. [s. 36.]

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 the licensee of a long-term care home must ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

During stage one of the RQI, resident #012 was triggered for having signs of improper continence care.

Resident #012 required assistance from staff for toileting.

The clinical records of resident #012 were reviewed and there was no documentation to indicate that a continence assessment was completed for the resident since their admission to the home. The resident's most current written care plan did not specify their continence status for bowel and bladder.

Resident #012 told the LTCH Inspector that they were incontinent of both bladder and bowel and required assistance from staff for their toileting needs.

PSW #126 was interviewed and stated that resident #012 was incontinent of bowel and bladder. PSW #126 reviewed the resident's most current written plan of care and indicated that it did not specify the resident's continence status.

The home's policy "Continence Management Program," directed staff to complete a continence assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence. The assessments were to be completed with all new admissions, for residents with deterioration in continence level, and with any change in condition that would affect bladder and bowel continence.

During an interview with RPN #127, they told the LTCH Inspector that resident #012 was incontinent. They added that it was the expectation that a Continence assessment was completed for each resident upon admission. They acknowledged that resident #012 did not receive a continence assessment upon admission or any other time after that, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (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 the licensee of a long-term care home must ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers were identified for the resident demonstrating responsive behaviours, where possible.

A CI report was submitted by the home to the MOHLTC stating that a staff member observed resident #007 exhibiting behaviour towards resident #030. A similar incident occurred on a different date, where resident #007 was observed exhibiting inappropriate behaviour towards resident #031.

The clinical record for resident #007 was reviewed and Dementia Observation Scale (DOS) was initiated post each incident. However, there was no analysis documented and there was no other documentation on the resident's clinical record which identified the possible behavioural triggers for the resident's inappropriate behaviour. There were no triggers identified on the resident's current responsive behaviour plan of care.

Interviews were conducted with PSW #136 and RPN #133 and they were unsure what the triggers were for the resident's behaviour.

The home's policy "Responsive Behaviours", directed staff to identify and document behavioural triggers whenever a behaviour was observed. It also stated that resident's care plan should include at a minimum triggers to resident's behaviours.

During an interview with the home's Behavioural Support Ontario (BSO) Lead, they told the LTCH Inspector that staff were responsible for identifying triggers for each resident exhibiting responsive behaviours. They acknowledged that no behavioural triggers were identified for resident #007's behaviours towards other residents.

The home has failed to ensure that behavioural triggers were identified for resident #007's behaviours. [s. 53. (4) (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 the licensee must ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations.

Resident #006's MDS assessment indicated that their behavioral symptoms had deteriorated.

A record review revealed that on a specific date, resident #006 had an altercation with a co-resident, resident #022. A Responsive Behaviors - Mental Health Debrief form was completed for resident #006 post incident with no identification of triggers or interventions for their behaviour or to minimize the risk of further altercations.

Upon record review and interview with PSW #129, it was found that resident #006 had a history of altercations with other residents.

In an interview with RPN #116, they acknowledged that it was expected that the care plan be updated after an incident of altercation to include triggers and interventions. The RPN was unable to provide documentation of whether triggers and interventions were identified after the incident.

The home's policy, "Responsive Behaviors," directed registered staff to update the plan of care with a description of the responsive behavior, have identified triggers and interventions to manage the responsive behavior.

The BSO acknowledged that there was no documentation of whether an analysis of the possible triggers or interventions to minimize the risk of further altercations was completed. In addition, the plan of care was not updated with possible triggers and/or interventions related to responsive behaviour or to minimize the risk of altercations in the future.

The home has failed to ensure that triggers were identified for resident #006, demonstrating responsive behaviors to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 54. (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 the licensee must ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations, 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. (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 a quarterly review was undertaken of all medication incidents that had occurred in the home since the last review in order to reduce and prevent medication incidents.

The Long-Term Care Homes (LTCH) Inspector reviewed the home's quarterly medication management reports for February and May 2018. The medication incidents were included in the home's Professional Advisory Committee (PAC) meetings.

The medication incidents were listed individually in section 7 of the report and did not reference the previous quarterly report. There was no analysis of the medication incidents and no changes recommended to improve the system.

During an interview with the home's Pharmacist Consultant, they stated they did not review the medication incidents relative to the previous quarter. They did participate in a safe medication meeting along with the Director of Care (DOC) and some staff where each individual incident was discussed. The home was not able to provide any documentation related to this process.

The Pharmacist Consultant stated that there were no changes recommended as a result of any evaluation of the individual medication incidents.

The Pharmacist Consultant and the Administrator acknowledged the home did not review the medication incidents in order to recommend changes to the program, since the time of the last review, in order to reduce and prevent medication incidents. [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 the 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, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record relating to falls prevention included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The LTCH Inspector reviewed the home's annual evaluation related to the fall prevention program.

The written record did not include the date of the evaluation and a summary of changes made to the program.

During an interview with the Administrator and the home's Long Term Care Consultant, they acknowledged that the annual fall prevention program review did not include the date of the review and any changes made to the program. [s. 30. (1) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the nursing and personal support services program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The LTCH Inspector requested the written record of the home's annual evaluation of the personal support services program from the Administrator.

The Administrator informed the LTCH Inspector their program evaluation was scheduled in May 2018 to review the April 1, 2017 to March 31, 2018, program period. They informed the LTCH Inspector the nursing and personal support services program evaluation had not been completed.

The Administrator acknowledged the home failed to complete an annual evaluation of the nursing and personal support service program. [s. 31. (3) (e)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

The Administrator provided an Evaluation of the Abuse program from January 2017, to the LTCH Inspector.

In an interview with the Administrator, they indicated that there was no evaluation for the Abuse program completed in 2018.

The licensee failed to ensure that an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences. [s. 99. (b)]

WN #13: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which included 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. They failed to ensure that the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year and identified changes to improve the system.

The LTCH Inspector reviewed the home's annual review of their medication management system and identified there was no registered dietitian present at the meeting, there were no reviews of the quarterly evaluations in the previous year and no changes identified to improve the system.

During an interview with the Pharmacist Consultant and the Administrator, they acknowledged the home did not include the registered dietitian, they had not reviewed the quarterly evaluations from the previous year nor had the home identified any changes to implement to improve the system. [s. 116. (1)]

Issued on this 23rd day of November, 2018

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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) :	ZINNIA SHARMA (696), FARAH_ KHAN (695), HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2018_728696_0008
Log No. / No de registre :	025431-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 9, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Halton Hills 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Emily Bosma

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_539120_0015, CO #001;

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 :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must:
Ensure that resident #001, #031, and any other resident are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO #001 from inspection #2018_539120_0015 issued on June 18, 2018, with a compliance date of July 6, 2018.

The licensee was ordered to;

a) The licensee must be compliant with s.19(1) of the LTCHA.

b) The licensee shall prepare, submit and implement a plan that summarizes how resident #101, or any other resident will be protected from harm or abuse by any employee or volunteer of the home. The plan must include, but is not limited to identifying what actions need to be taken by the licensee to ensure that employees are following the licensee's prevention of abuse and neglect policies and procedures, specifically with respect to reporting suspicions or allegations of abuse and subsequently taking appropriate actions to investigate allegations of abuse.

c) Please submit the written plan for achieving compliance to Bernadette Susnik,

LTC Homes Inspector, MOHLTC, by email to Bernadette.susnik@ontario.ca by July 6, 2018.

The licensee completed part b) and c) in CO #001.
The licensee failed to ensure that part a) of CO#001 was completed.

The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A. For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

During stage one of the Resident Quality Inspection (RQI), a resident reported to the Long-Term Care Homes (LTCH) Inspector that a particular staff member had been rude to them and were making degrading comments about them.

The LTCH Inspector reported the abuse to a staff member. The resident explained to the staff member that the degrading comments were made regularly and they had not reported it because they were afraid of facing retaliation.

In an interview with RPN #117, the RPN indicated that talking down to a resident or saying negative things about them would be considered abuse.

The home's policy, "Zero Tolerance of Resident Abuse and Neglect Program," included in its definition of verbal abuse, comments that diminish a resident's sense of well-being, dignity or self-worth. The policy indicated that there was a zero tolerance for abuse and neglect and that any form of abuse, whether deliberate acts or negligence, would not be tolerated.

In an interview with the Administrator, they acknowledged that based on interviews with the resident and co-staff, it was determined that verbal abuse did occur.

The licensee has failed to ensure that the resident was protected from verbal abuse by anyone. (695)

B. A Critical Incident (CI) report was submitted by the home to Ministry of Health and Long Term Care (MOHLTC) stating that a staff member observed resident #007 exhibiting inappropriate behaviour towards resident #031.

The clinical record for resident #031 was reviewed. It was documented that on a particular date a registered staff observed resident #007 exhibiting inappropriate behaviour towards resident #031. There was no documentation to indicate that behaviour was consensual in nature.

The home's investigation indicated that interaction between the two residents was non-consensual in nature.

During an interview with RPN #134, they said that resident #007 had exhibited inappropriate behaviour towards resident #031.

The licensee has failed to ensure that resident #031 was protected from abuse by resident #007. (696)

The severity of this issue was determined to be a level 2 as there was Minimal Harm or Potential for Actual Harm. The scope of the issue was a level 2, pattern. The home had a level 4 history as they had a related non-compliance with this section of the LTCHA that included:

- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on December 5, 2016 (2016_215123_0012).
- Compliance Order (CO) #001 issued June 6, 2018 with a compliance due date of July 6, 2018 (2018_539120_0015). (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 20, 2018

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. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with s. 50 (2) of O. Reg. 79/10.
Specifically the licensee must:
a) Ensure that resident's #009, #015, #029, and any other resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. During stage one of the RQI, resident #015 was triggered for skin impairment.

The LTCH Inspector reviewed the clinical record for resident #015 and found that the resident had acquired a new area of altered skin integrity on a specific date.

The home's policy "Skin and Wound Program: Wound Care Management", directed registered staff to re-assess areas of altered skin integrity on a weekly basis.

The LTCH Inspector reviewed resident #015's clinical record which revealed that there were two weekly skin assessments that were not completed for the area of altered skin integrity. There was no other documentation to indicate that staff had completed a weekly skin assessment for those two weeks.

During an interview with Registered Nurse (RN) #137, they stated that after a new area of altered skin integrity was identified registered staff were expected to do a weekly skin assessment until the skin issue had been resolved. The LTCH Inspector and the RN reviewed the weekly skin assessment records of the resident and they acknowledged that the registered staff did not complete any weekly skin assessments for resident #015's altered skin integrity for those two weeks. (696)

B. Resident #029 required assistance from staff with activities of daily living and were at moderate risk of altered skin integrity.

On a specific date, the resident was identified to have a new area of altered skin integrity. On a different date, they were identified with another area of altered skin integrity.

The LTCH Inspector reviewed the clinical record of resident #029 and found the weekly assessments of both the areas of altered skin integrity were not completed as required. Both the areas of altered skin integrity were included in the one tool, however, only one set of notes was documented on the tool. On a specific date, neither of the two areas of altered skin integrity were assessed.

During an interview with RPN #135 and the DOC, they both told the LTCH Inspector that weekly skin assessments should be conducted on the altered skin integrity until they had healed. They both stated it was an expectation that each area of altered skin integrity be assessed using an individual assessment instrument.

RPN #135 acknowledged the home failed to complete weekly assessments for the areas of altered skin integrity.

C. Resident #009 was assessed to require assistance with all activities of daily living and was at moderate risk of altered skin integrity.

On a specific date, the resident was identified with altered skin integrity.

The LTCH Inspector reviewed the clinical record of resident #009. On three occasions out of a required 24, the weekly wound assessments were not completed.

During an interview with RPN #109, they told the LTCH Inspector the resident acquired the altered skin integrity on a particular date and it never fully healed. They stated that it was expected that weekly wound assessments would be conducted on the altered skin integrity until they had healed.

RPN #109 acknowledged the home failed to complete all weekly assessments

for the altered skin integrity.

The home has failed to ensure that resident #015, #029, and #009 who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff. (640)

The severity of this issue was determined to be a level 2 as there was Minimal Harm or Potential for Actual Harm. The scope of the issue was a level 3, widespread. The home had a level 3 history as they had a 1 or more related NC in last 36 months with this section of the LTCHA that included:

- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on October 26, 2017, (2017_482640_0013). (696)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 04, 2018

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 9th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Zinnia Sharma

Service Area Office /
Bureau régional de services : Central West Service Area Office