Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 26, 2020	2020_583117_0012 (A1)	008427-20, 008819-20, 009795-20, 010152-20, 010265-20, 010637-20, 010694-20, 010764-20, 011676-20, 012330-20	Complaint

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 Laurier Manor
1715 Montreal Road GLOUCESTER ON K1J 6N4

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

A request was received for an extension to the compliance due date of August 28 , 2020, related to the compliance order CO #002 OREG s. 114 (3). This request was reviewed and granted. The new compliance due date is September 11, 2020.

It is also noted that a correction in the finding O.Reg. s. 114 (3) was done.

Issued on this 26th day of August, 2020 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

Ontario

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Ministère des Soins de longue durée

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

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

This inspection was conducted on the following date(s): May 21,22,25,26,27,28,29 - June 1,2,3,4,5,8,9,10,11,12,15,16,17,18,19,22,23,24,25,26,29,30 - July 2,3,6,7,8 and 9, 2020 - it is noted that onsite inspections were conducted on May 21, June 4,12,19,24 and July 6, 2020. It is noted that the Long-Term Care Home was in a COVID-19 outbreak from April 13 to June 16, 2020.

This inspection includes the following ten (10) complaints and critical incidents:

• Log # 008427-20: complaint related to COVID-19 outbreak management and infection control practices, nutrition and hydration, housekeeping services and staffing

• Log # 008819-20: complaint related to resident continence care, skin and wound care, nutrition and hydration, pest control, infection control practices and COVID-19 screening and testing

• Log # 009795-20: a critical incident related to an alleged incident of staff to resident physical abuse

• Log # 010152-20: a critical incident related to Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status

• Log # 010265-20: a critical incident related to Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status

• Log # 010637-20: a critical incident related to Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status

• Log # 010694-20: a complaint related to COVID-19 infection control practices, pest control management, staffing, provision of personal care, continence care, fall prevention management, skin and wound care, responsive behaviours, pain management, alleged verbal abuse, and medication administration and

medication management system as well as staff training

• Log # 010764-20: a complaint related to responsive behaviours, resident equipment maintenance, personal care, continence care, skin and wound care, medication administration, falls prevention program.

• Log # 011676-20: a critical incident related to Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status

• Log #012330-20: a critical incident related to an alleged incident of staff to resident verbal abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Dietitian (RD), Extendicare Consultant, Pharmacist, Physicians, Registered Practical Nurses (RPNs), Registered Nurses (RNs), Personal Support Workers(PSWs), Recreational-Activity Staff, maintenance and housekeeping staff, staff from a hospital (HOS) as well as residents.

The Inspector(s) reviewed the health care records of the identified residents, observed the provision of resident care and services, observed resident rooms and common areas, observed several meal services, observed several medication administration passes as well as reviewed the home’s medication administration management system, observed infection control practices and COVID-19 screening processes, reviewed registered and non-registered staffing, reviewed communications with Hospital COVID-19 Support Team, reviewed communications with The Ottawa Public Health Unit and reviewed the home's preventative pest control program. In addition, the following licensee policies were reviewed:

• Falls Prevention and Management Program, RC-15-01-01

• Power of Attorney – Personal Care, RC-04-01-07

• Skin and Wound Program: Prevention of Skin Breakdown, RC-23-01-01

• Emergency Starter Box, Policy 2-4 (by Medical Pharmacies)

• Sharps Handling, RC-25-01-44

• Self-Administration of Medication, RN-16-01-15,

• Subcutaneous Medication Infusion dated 10-6, 2 / 17 (by Medical Pharmacies)

• Reallocation of Injectable Products COVID-19 Pandemic Emergency Measure (3/20)" (by Medical Pharmacies)

• Shift Change Monitored Drug Count, 6-6 (by Medical Pharmacies)

• Drug Destruction and Disposal, 5-4 (by Medical Pharmacies)

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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

- **14 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

It is noted that as per the CMOH Directive #1 for Health Care Providers and Health Care Entities (Revised March 30, 2020), CMOH Memo: Directive # 3 for Long-Term Care Homes (May 23, 2020), COVID-19 Guidance: LTC Homes, version 4, April 15, 2020, Guidance for mask use in LTC homes and retirement

homes, version 1 – April 15, 2020, and Personal Protective Equipment (PPE): Guidance for the LTC & RH Sectors, Version 1.0, April 20, 2020, all long term care home staff are to wear face masks at all times when in a long-term care home.

On May 21, 2020, during observation of a resident home area, Inspector #117 and # 756 observed PSW # 102 providing feeding assistance to a resident in room while not a wearing a mask. PSW #102 said that they had just come back from their lunch and forgotten to put on a mask. The PSW then went to a wall mounted Personal Protective Equipment (PPE) carrier, did not wash their hands, selected a face mask and put on the mask inside out. The PSW did not put on a face shield

The home's administrator and acting DOC stated that staff on the unit are to wear a mask and face shield at all times. Other PPEs, such as gloves and gowns, are to be used when providing direct resident care and in accordance with each resident's plan of care.

As such, PSW #102 did not participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. As per Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 initially issued on March 22, 2020, and having regard to the immediate risk to residents of COVID-19 in long-term care homes and retirement homes, the necessary, present, and urgent requirement to implement additional measures for the protection of staff and residents, including, but not limited to, the active screening of residents, staff and visitors, active and ongoing surveillance of all residents, screening for new admissions, managing essential visitors, changes to when an outbreak of COVID-19 is declared at a home, including when it is over, and specimen collection and testing for outbreak management;

June 3, 2020, management staff #160 came to work at the LTC home and was screened at LTC home entrance for COVID-19. Later in the day, ADOC #101 asked hospital staff #125 to swab management staff #160 for COVID-19 as staff #160 was presenting with atypical symptoms of COVID-19. Hospital staff #125 said that management staff #160 had informed them that they had not reported their atypical symptoms at the time of their entrance screening.

On June 3, 2020, the licensee failed to ensure that management staff 106 participated fully in the implementation of IPAC. (Log #010694-20) [s. 229. (4)]

3. Directive #3, dated April 15, 2020, for Long-Term Care homes under the Long-Term Care homes Act, 2007, states that long-term care homes should immediately ensure that all staff wear a surgical/procedural masks at all times. On June 24, 2020, staff member #174 was observed in the main office speaking with another staff member and staff member #174 was not wearing a procedural/surgical mask. [s. 229. (4)]

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. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies for the medication management system are implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. (Log

#010694-20)

Resident #022 is identified as having some cognitive impairments. On a specified day in 2020, inspector #117 observed that the resident had a medication at their bedside table. The prescription label indicated that the resident is to take a specified dosage up to 4 times a day, as needed, and that the medication can be left at the resident's bedside.

Inspector #117 spoke with the resident regarding the medication. When asked about the use of the medication, resident #022 could not provide information as to when they last took the medication and how many doses of the medication they have taken. The inspector also asked resident #022 if they informed the unit nursing staff when they had taken the medication. The resident said that they do not recall informing the unit nursing staff when they take the bedside medication. Resident #022 indicated that they keep the medication out in the open, on top of the bedside table, which is located at the room entrance.

A review of the resident's medication order was done with RN # 133 and RPNs #132 and #134. On a specified day in 2020, the resident's then attending physician, prescribed that two identified medication be at bedside for patient use as needed and for staff to review the instructions with the resident. It was also noted that thirteen (13) days later one medication order was reviewed and discontinued by the resident's new attending physician. However, the order for the other medication remained unchanged.

Further review of the eMAR for two identified months in 2020 indicate that the observed medication had been at the resident's beside since the day of the original prescription order. Its use was documented on two occasions on the eMAR. The eMARs also document that the discontinued medication was at the resident's bedside a total of 13 days. Its use was documented on one occasion.

RPNs #132 and #134 said that they were aware of the order to have the two prescribed medications at the resident's bedside as well as the presence of these medications at the resident's bedside. Both RPNs said that the resident has some cognitive impairments and that resident #022 has difficulties in providing information to nursing staff regarding their self-administration of the prescribed medications.

The DOC said to the inspector that they had recently been made aware that

resident #022 had a prescription for a bedside medication. The DOC said that no medications are to be left at resident bedsides unless the residents had been assessed as to their ability to self-administer, as per the licensee's policy.

As such, the licensee's policy #RC-16-01-15 "Self-Administration of Medication" was not implemented. [s. 114. (3) (a)]

2. The Pharmacy Policy and Procedure Manual for LTC Homes from Medical Pharmacies, the licensee's pharmacy services provider indicates the following : " 10-6 Subcutaneous Medication Infusion", dated 2 / 17,
"Once the desired quantity is drawn into the syringe, the remaining quantity should be discarded using procedures appropriate to medication (e.g. wasting of a monitored medication requires a witness and appropriate documentation). Do not save residual mediation for subsequent injections unless explicitly directed by administrative staff and/or manufacturer. The storage of opened ampoules with residual medication is not acceptable."

"The practice of saving the entire contents of an ampoule by drawing up multiple syringes for future injections is strongly discouraged and is generally considered to be unsafe practice except in 'dire circumstances' (e.g. drug shortages) and/or when explicitly directed by administrative staff and/or the manufacturer."

On a specified day in 2020, RPN #112 prepared a monitored injectable medication for residents #027 and #028. As per the Narcotic Monitoring Record (NMR), one ampoule of the identified medication was used to draw one dose for resident #027 and another dose for resident #028. The NMR documents that a certain dose of the medication was wasted. There is no witness signature to the wastage of the monitored medication on the NMR.

RPN #112 said to inspector #117 that they did prepare, by them self, both resident's medication, using the same ampoule, as they were concerned with possible medication shortage due to the COVID-19 outbreak in the home.

As per Pharmacist #177, the licensee has a policy regarding the use of injectable medication. No injectable medication ampoules are to be used to draw multiple medication dosages unless explicitly directed. Pharmacist #117 said that Medical Pharmacies did not provide any directives regarding the drawing of multiple doses from injectable medication ampoules during the licensee's COVID-19 outbreak.

(Log #010694-20) [s. 114. (3) (a)]

3. On a specified day in 2020, a complaint was received stating that RN #153 did not follow proper needlestick handling procedure after providing an intramuscular injection of a medication to resident #035 on a specified day in 2020.

The Licensee's Sharps Handling Policy, #RC-25-01-44, last updated February 2017, defines a sharp as needles and syringes with needles attached. This policy states that the nurse is to ensure that sharps are not transported from the site of use for disposal and that following the administration of an injectable medication the nurse immediately deploy the safety engineered mechanism and then place the sharp in the puncture resistant container at site of use.

On a specified day in 2020, there is an administration record and progress note for a prescribed medication administered by intramuscular injection to resident #035 by RN #153.

Staff member #125 stated that after RN #153 administered a medication via intramuscular injection, RN #153 did not deploy the safety cap on the needle and exited the room. The ADOC #135 confirmed that RN #153 did not cap the needle immediately after administering the medication, and only capped the needle at the doorway of the room after another staff member yelled out to do this.

As such, the licensee's Sharps Handling policy was not implemented by RN 153 on a specified day in 2020. (Log #010764-20) [s. 114. (3) (a)]

4. The Pharmacy Policy and Procedure Manual for LTC Homes from Medical Pharmacies, the licensee's pharmacy services provider indicates the following : " REALLOCATION OF INJECTABLE PRODUCTS COVID-19 PANDEMIC EMERGENCY MEASURE (3/20)"

The policy states the following:

Action:
• Medications to be reallocated in the home are: Morphine, HYDROmorphone, Midazolam, Lorazepam, Haloperidol, Glycopyrrolate, Methotrimeprazine (Nozinan) and Scopolamine.

• Injectable products may only be reallocated within the home (not returned to pharmacy)
• The reallocation is ideally completed by a pharmacist (or physician) and Director of Care/Wellness (DOC/DOW), or registered staff delegate, for the duration of the pandemic only.
• In circumstances where a pharmacist or physician is not available, the DOC/ADOC and nurse may complete the reallocation.
• Proper documentation of the reallocated drug must be traceable and auditable (use Reallocation Log and Shift Counts)

Procedure:
Nurse:
1. Process discontinued orders as per standard nursing procedures followed in the home (i.e. place narcotic injectables in wooden narcotic destruction box).
Pharmacist (or Physician) and DOC/DOW (or delegate) OR a DOC/DOW and a nurse:
2. Examine injectable products for tampering and ensure supply is not expired.
3. Complete proper documentation (for narcotic injectables) on the Drug Destruction and Disposal Narcotic and Controlled Substances form, however, do not destroy any of the injectable products.
- Document “Reallocated to ESB “and date next to any entry being reallocated from destruction.
- Add reallocated drug information and quantities to the Narcotic Shift Count sheet specifying this is a “Reallocated Supply”.
4. Attach a new label to reallocated products:
- New label must include date, drug name, strength, lot #, expiry date, and a name line for entry of future resident name.
- New label must have Pharmacist/Physician or Nurse name and signature
5. Complete Reallocation Log (for all reallocated supply) and store Log with ESB
6. Transfer reallocated supply and store with the ESB as per standard procedure.
7. Homes that do not have an ESB or enough space in their current ESB, can assign another locked box or cupboard for storage of the reallocated medication and clearly label it “Reallocated Supply”.

On a specified day in 2020, resident #040’s monitored injectable medication was discontinued.

As per the Narcotic Monitoring Record (NMR), resident #040’s discontinued

monitored medication was used on the next day by RPN #112 to prepare prescribed medication and administer these to residents #027, #028 and #041. Three and five days later, this same discontinued medication was used by RPN #184 to prepare prescribed medication and administer these to residents #001 and #041. The discontinued monitored medication was not reallocated as per the policy to an identified emergency drug box, resident #040 identifiers were not removed from the medication nor was the medication identified and clearly labelled as “Reallocated Supply”.

RPN #112 said to inspector #117 that they did use the discontinued medication of resident #040 to prepare prescribed medication for residents #027, #028 and #041. The RPN said that this was done as they were concerned with possible medication shortage due to the COVID-19 outbreak in the home. The DOC said that they had given directions to RPN #112 for the reallocation of the discontinued medication as they were concerned with possible medication shortage due to the COVID-19 outbreak in the home.

As per Pharmacist #177, the licensee’s policy regarding the reallocation of discontinued monitored medication was not put into force during the COVID-19 outbreak. They communicated to the home’s DOC and ADOC #119 on specified day, that to avoid any shortage of supplies, Medical Pharmacies needed to be informed when staff were removing the identified medication from the emergency supply and who they were using it for so that they could replace the medication the same day. They also communicated that to request refills and higher quantities of medication for residents who have active orders so that the registered nursing staff won’t need to use the emergency drug box. Pharmacist #177 indicated that Medical Pharmacies had made deliveries of the identified monitored medication five days prior to the reallocation of medication. Three days later, Medical Pharmacies was informed that the LTC home’s emergency drug box identified monitored medication had ran out the day before and pharmacy sent out a full amount of the medication in a special delivery to the home that day. As per the pharmacist, no request for the medication was received by the pharmacy between the two delivery dates. Pharmacist #117 said they nor their colleagues were advised or notified of the reallocation of resident #040's discontinued monitored medication on a specified day or thereafter.

As such, the licensee’s policy on the reallocation of medication was not followed by RPN #112, #184 and the DOC. (Log #010694-20) [s. 114. (3) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to the use of mobility aids. (log #010265-20)

Resident #015 had a fall on a specified day in 2020. A critical incident report (CIS # 2674-000025-20) was submitted to the Director regarding the incident as the resident sustained an injury for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the resident's health care record identified that resident #015 was at high risk of falls due to previous history of falls and balance issues. The plan of care, in place since admission, prior to the Order in Council: Order Under Subsection 7.0.2(4) of the Act – Streamlining Requirements for Long-Term Care Homes – Signed March 27, 2020 related to focus documentation only on significant incidents or to ensure the proper care and safety of a resident, did not identify the resident's mobility and ambulation needs.

On a specified day, it was observed that a 4-wheeled walker was in the resident's room. A logo at the resident's head of bed indicated that the resident required 1-person supervision for mobility and transfer. PSW #127 said that the resident did use the walker to mobilize to the dining room however, would not use it for short distances or about the resident's room. The PSW said that the resident was independent with short distance mobility such as in the resident room but did require staff supervision for ambulation on the unit and elsewhere in the home. RN #129 and RPN #130 both said that the resident was at risk for falls and did use a walker for ambulation to the dining room with occasional staff supervision.

The resident's written plan of care, in place at the time of the resident's fall and injury, did not identify that the resident used a walker for mobility and required staff supervision during ambulation. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #030 as specified in the plan. (Log #010694-20)

Order in Council: Order Under Subsection 7.0.2(4) of the Act – Streamlining Requirements for Long-Term Care Homes – Signed March 27, 2020. The emergency order provides flexibility and alleviate burden on long-term care homes during the pandemic by:
Documentation
• Focus documentation only on significant incidents or to ensure the proper care and safety of a resident

Resident #030 has an order, written November 8, 2017, stating “reduced post fall VS to 24 hours if no head injury”.

On a specified day in 2020, resident #030 was found with their lower body on the floor and their upper body on the bed. A Post Fall Assessment was completed. In the 24-hour period following the fall, the resident’s vital signs (with the exception of temperature) were not recorded as per order, which is part of the plan of care. [s. 6. (7)]

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

On a specified day in 2020, a complaint was received alleging that resident #020 was not being provided personal care on a regular basis.

On three specified days in 2020, INSP #756 observed resident #020 following the provision of personal care. On two identified days, resident #020 was noted to have not been provided mouth care or hand nail care. In addition, on a third day, resident #020 was again noted to have not been provided hand nail care. Resident #020’s teeth were in the same condition on two specified days, which was observed as having a large amount of white debris between each tooth. As well, resident #020’s nails on both hands were long and had not been trimmed on all three dates.

Resident #020’s Care Record shows that staff members signed that resident #020 received a bath and personal care on two specified days and personal care on a third specified day. When interviewed resident #020 stated that they preferred to have their nails trimmed shorter.

PSW #150 stated that resident #020 is provided with mouthcare and nail care, however was unable to locate mouthcare supplies in resident’s room. PSW #146 also stated that resident #020 is provided with mouthcare however they also could not locate mouthcare supplies in resident’s room. PSW #162 stated that resident #020 should receive nail care on one of their bath days. Therefore resident #020 should have received nail care on either of two specified dates but did not.

PSW #150 also stated that they provide resident #020 with personal care without

a second staff member to assist. Resident #020's care plan states that there should always be 2 staff members to assist for personal care and dressing as the resident has pain due to physical condition and can be resistive during care. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #025 as specified in the plan. (Log #010694-20)

Resident #025 has bladder and bowel incontinence. Their plan of care directs staff to keep their skin clean and dry due to concerns for impaired skin integrity

On a specified day in 2020, the resident was noted to have a reddened coccyx and ischium. A cream was applied. Three days later, the resident's buttocks were recorded as being excoriated, and their groins red. A cream was applied. The next day, while performing a skin assessment, RPN #169 noted that the resident's excoriated skin was due to bowel and bladder incontinence. A new treatment twice daily was implemented. Two days after this assessment, the physician noted the presence of moderate excoriation in the area due to incontinence and noted that the resident required frequent changing of their continence product. A new treatment with medicated cream and medicated powder as needed was implemented.

Resident #025's care set out in the plan of care was not provided to keep their skin clean and dry. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident and to ensure that the care set out in the plan of care was provided to resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The Licensee failed to ensure that consent was received when resident #012's medication treatment plan of care was revised.

Resident #012 was admitted to the home on a specified day in 2020, after discharge from an out of region Health Network. On admission, the Licensee had the discharge paperwork from the Health Network that stated resident #012 was found incapable of decision making on a specified day in 2020, and identified the resident's friend, whom the resident lived with, as the Power of Attorney (POA). The resident's friend signed several Licensee documents on admission as the Substitute Decision Maker (SDM). Ten days after admission, DOC#121 documented in the healthcare record that the resident's friend is POA and that they advised the SDM should any changes to medications be made, that the Licensee would need approval from the SDM before initiating the medication.

On a specified day in 2020, the new attending physician, Physician #172, questioned the validity of the identified POA for this resident and the need to notify them of changes to resident treatment and medication. This was both

documented by RPN #149 on a specified day in 2020, and the Physician #172 two days later, in the resident's healthcare record.

The Licensee's policy Power of Attorney - Personal Care, #RC-04-01-07, last updated April 2017, states the Power of Attorney (POA) for Personal Care must be contacted for consent for any significant change in the resident's health care and treatment plan. The policy also states that if the POA is not available or willing to make a decision, then the highest-ranking Substitute Decision-Maker (SDM) who is available and willing to make a decision will be contacted.

Resident #012's friend and a family member contact information were both identified in the resident's healthcare record. Neither were contacted for the change in physician on a specified day. In addition, neither were contacted about changes to resident #020's medication on nine (9) specified days. On another a specified day, RN #154 documented that they contacted the resident's family member due to a change in the resident's condition and medication. During this contact, the family member identified them self as the legal SDM and was subsequently listed as POA in the healthcare record. However, the family member was still not notified of the resident's medication changes on three (3) specified days after being identified as the POA by RN #154.

Physician #172 was interviewed by Inspector #117 and confirmed that they questioned the validity of the friend's POA/SDM status for this resident and was not aware that the family member was the legal SDM. RN #154 and RPN #149 both confirmed that they did not obtain consent for changes to resident #012's medication treatment plan. [s. 29.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. (Log # 010694-20)

As per the Order in Council: Order Under Subsection 7.0.2(4) of the Act – Streamlining Requirements for Long-Term Care Homes – Signed March 27, 2020. The emergency order provides flexibility and alleviate burden on long-term care homes during the pandemic by:
• Focus documentation only on significant incidents or to ensure the proper care and safety of a resident

Resident #027 was diagnosed as having COVID-19 on a specified day in 2020. The next day the resident's health condition deteriorated rapidly. The resident was seen by the Nurse Practitioner (NP) # 141 who ordered some medications to be administered to the resident. RPN # 111 was also present, assisting NP#141 with

the provision of resident care. Medical order sheet documents that on that specified day resident #027 was transferred to hospital at POA request. There is no time as to when this was written in the medical order form. Further review of the resident's health care record indicates the next day that the resident was at the hospital. Later that same day, that the resident had passed away.

RPN #111 and #112, HOS RPN #125, HOS Supervisor #122 and Extendicare Consultant # 170 all said that the resident's health condition was rapidly deteriorating. HOS RPN # 125 and Extendicare Consultant #170 said that the HOS team did implement a specified intervention as per NP orders. RPN #112 documented in a narcotic control record that they prepared a monitored injectable medication for administration to the resident as per NP # 141 orders prior to the resident being transferred to hospital.

RPN #111 said that the resident was transferred to hospital on a specified day. RPN#111 said they were so busy due to the COVID-19 outbreak, that they are unsure if they documented resident care. Extendicare Consultant #170 also indicated that at that time HOS nursing staff were not documenting in resident health care records.

A review of the resident's health care record was conducted and there is no documentation of the resident's rapidly declining health condition, implementation of an intervention, administration of a medication and transfer to hospital on a specified day. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. (Log #010694-20)

On a specified day in 2020, resident #027 was prescribed a specific dose of a monitored injectable medication. As per the Narcotic Monitoring Record, RPN #112 prepared a different dose of the monitored injectable medication for the resident. As per HOS RPN #125 and Extendicare Consultant #170, RPN #112 administered the medication to resident #027 prior to their transfer to hospital. RPN #112 said they did administer the prescribed medication to the resident, but they do not remember the medication dose administered. It is also noted that the administered medication was not documented in the resident's eMAR.

As such, the Narcotic Monitoring Record documents that a specified dose of the monitored injectable medication was prepared for the resident instead of the prescribed dose. As such, the monitored injectable medication was not administered to resident #027 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. (Log #010694-20)

On a specified day in 2020, resident #028 prescribed a specific dose of a monitored injectable medication. As per the Narcotic Monitoring Record, RPN #112 prepared a different dose of the monitored injectable medication for the resident. In the resident's eMAR, it is documented that documents that a specified dose of the monitored injectable medication was administered to the resident instead of the prescribed dose by RPN #112. The RPN said that they do remember administering the resident's medication but does not remember the medication dose administered to resident #028.

As such, the Narcotic Monitoring Record documents that a specified dose of the monitored injectable medication was prepared for the resident instead of the prescribed dose. As such, the monitored injectable medication was not administered to resident #028 in accordance with the directions for use specified by the prescriber [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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, (b) is complied with. (Log # 011676-20)

As per O.Reg. s. 48 (1) the licensee is to have a Falls Prevention and Management Program as well as to have policies and procedures for this program.

The licensee's Fall Management and Prevention Policy #R15-01-01, December 2019, page 6 under Post Fall Management indicates the following:
- report any incidents of a resident found on the floor or a resident fall immediately to the nurse
- ensure that, prior to the resident being transferred, or assisted to ambulate post-fall, the resident is assessed by a nurse
- transfer the resident post-fall, unless the resident is able to get up on their own, and only after the nurse has assessed the resident and approved the transfer.

On a specified day in 2020, resident #039 sustained a fall with injury while receiving toileting assistance from agency PSW #176. PSW #176 assisted the resident back to their bed prior to notifying RN #171 of the resident's fall and injury.

RN #171 and ADOC #159 said to inspector #117, that agency PSW #176 had worked several times on the resident home area prior to the resident's fall. RN #171 said that they had informed the agency PSW #176, to notify nursing staff immediately if there should be resident fall and not to move the resident until a registered nurse had made an assessment. As such agency PSW #176 did not follow and implement the home's Post Fall Management procedure [s. 8. (1)]

WN #8: 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 are maintained in a safe condition and in a good state of repair. (log # 010764-20)

On a specified day in 2020, it was reported in a unit’s maintenance log book that an identified bed had a bed wheel that was broken. As per the review of the maintenance log book, there was no information noting that maintenance services had taken action to address the broken bed wheel.

One month later, another entry was made in the maintenance log book regarding the bed having a broken bed wheel. Three days later, there was a note made by maintenance staff # 126 that the bed wheel had been fixed.

HOS staff # 116, staff member #157 said they and resident #031 had complained that the bed was lopsided. Maintenance staff #142 and #126 said that both went several times to assess the bed and try to repair the bed but could not do so as resident #031 occupied the bed. Maintenance staff #142 said that the residents cannot be in their bed to repair beds and bed wheels. Maintenance staff #142 and #126 said that they did not communicate with nursing staff to coordinate with them when resident #031 might be up from the bed to then go and action the repair. It is noted that the bed wheels were repaired on a specified day, when resident #031 was moved to another room and bed. [s. 15. (2) (c)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. he licensee failed to ensure that an alleged incident of resident abuse was immediately investigated. (Logs #010764-20 and # 012330-20)

Order in Council: Order Under Subsection 7.0.2(4) of the Act – Streamlining Requirements for Long-Term Care Homes – Signed March 27, 2020.
The emergency order provides flexibility and alleviate burden on long-term care homes during the pandemic by: Reporting
• Only mandatory reports and critical incidents to be reported to the Director

On a specified day in 2020, HOS supervisor #122 reported an incident of alleged verbal abuse of resident #032 by PSWs #161 and #162, to the LTC home's Administrator and DOC.

Fourteen (14) days later, the DOC and ADOC #159 initiated an internal investigation into the alleged incident of abuse. [s. 23. (1) (a)]

WN #10: 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 person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (Log #010764-20)

On a specified day in 2020, an alleged incident of verbal abuse of resident #032 by PSW #161 and #162 was witnessed by HOS staff #168. HOS staff #168 said that they had not immediately reported the alleged abuse to the LTC home, their HOS supervisor #122 or to the Director.

On a specified day, fourteen (14) days later, the alleged incident of verbal abuse was reported by HOS staff #168 to HOS supervisor #122. The HOS supervisor then reported the alleged incident to the LTC home Administrator and DOC the next day. [s. 24. (1)]

WN #11: 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 has failed to ensure that resident #025 who was exhibiting altered skin integrity was assessed by a registered dietitian.

Order in Council: Order Under Subsection 7.0.2(4) of the Act – Streamlining Requirements for Long-Term Care Homes – Signed March 27, 2020, the emergency order provides flexibility and alleviate burden on long-term care homes during the pandemic by:
Documentation
• Update care plans only where the changes are significant or contain information other staff needs to be aware of immediately

On a specified day in 2020, RPN #143 wrote a progress note stating that resident #025 had altered skin integrity at three identified areas.

Four days later, RPN #164 wrote a progress note stating that an area of the resident's skin was excoriated, and a specific treatment was initiated. On the same day, the resident's skin was assessed by RN #154 who noted reddened skin on another area and a pressure ulcer at another location. In an interview with the RD, they stated that any new or worsening skin wounds should be referred for an assessment and confirmed that a referral was not received.

The resident exhibited altered skin integrity on specified days. Resident #025 was not assessed by a registered dietitian. [s. 50. (2) (b) (iii)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to resident #025, the investigation was not commenced immediately.

On a specified day in 2020, the licensee received a written complaint with several concerns related to the care of resident #025.
The licensee began their investigation sixteen days after the complaint was received.

An investigation was not commenced immediately on a specified day when the complaint which alleged harm or risk of harm to resident #025 was received. [s. 101. (1) 1.]

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

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an incident has occurred that caused an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, has the licensee:

b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident (Log # 011676-20)

Order in Council: Order Under Subsection 7.0.2(4) of the Act – Streamlining Requirements for Long-Term Care Homes – Signed March 27, 2020.
 The emergency order provides flexibility and alleviate burden on long-term care homes during the pandemic by: Reporting
• Only mandatory reports and critical incidents to be reported to the Director

On a specified day in 2020, resident #039 sustained a fall with injury. The resident was assessed by RN #171 and the resident was transferred to hospital for further assessment. The next day, RN #154 notified the Director via the after-hours pager of the resident’s change in condition and transfer to hospital. It is noted that the resident returned to the LTC home later that same day, having received a treatment intervention for the sustained injury. A critical incident report (CIS) was sent to the Director on a specified day, five (5) business days after the Director had been notified of the resident’s injury and transfer to hospital [s. 107. (3.1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On a specified day in 2020, a complaint was received stating that a Personal Support Worker (PSW) transported a medication from the Emergency Drug Supply to another unit.

In a statement and in documentation in resident #012's healthcare record, on a specific day Staff Member #143 identified that they required a medication from the Emergency Drug Supply. They were unable to locate, by phone or in person, the Charge nurse who had access to the Emergency Drug Supply during that shift but notified the other staff members on that floor and the other Registered Nurses in the home. The requested medication was later brought to Staff Member #143 by a Personal Support Worker. Staff member #143 identified the charge nurse as RN #186.

On a specified day, there is an entry on Medical Pharmacies' Emergency Started Drug Record Book Sheet for the requested medication for resident #012. RN #145 confirmed that the signature for this entry was RN #186.

When interviewed, RN #186 stated that any staff member can transport a medication between floors of the home and that the staff member does not have to be a Registered Staff. DOC #121 confirmed that Personal Support Workers should never be handling medication. [s. 130. 2.]

Issued on this 26th day of August, 2020 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LYNE DUCHESNE (117) - (A1)
Inspection No. / No de l'inspection :	2020_583117_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008427-20, 008819-20, 009795-20, 010152-20, 010265-20, 010637-20, 010694-20, 010764-20, 011676-20, 012330-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 26, 2020(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Laurier Manor 1715 Montreal Road, GLOUCESTER, ON, K1J-6N4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chris Smith

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, r. 229 (4)

The licensee shall ensure that all staff participate in the implementation of the program in relation to the wearing of personal protective equipment (PPE) and COVID-19 active screening and ongoing surveillance of all staff by completing the following:

1. ensure that all staff of the LTC home wear a face mask at all times when in the home, except during breaks/meals;
2. ensure every person entering or leaving the LTC home is actively and consistently screened in accordance with established processes;
3. conduct audits at least twice weekly to assess compliance by staff to established processes and procedures related to the wearing of face masks and active screening; and
4. implement and re-evaluate corrective actions to address any identified deficiencies while ensuring that lessons learned are incorporated into the quality improvement processes and that these be documented

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

It is noted that as per the CMOH Directive #1 for Health Care Providers and Health Care Entities (Revised March 30, 2020), CMOH Memo: Directive # 3 for Long-Term Care Homes (May 23, 2020), COVID-19 Guidance: LTC Homes, version 4, April 15, 2020, Guidance for mask use in LTC homes and retirement homes, version 1 – April 15, 2020, and Personal Protective Equipment (PPE): Guidance for the LTC & RH Sectors, Version 1.0, April 20, 2020, all long term care home staff are to wear face masks at all times when in a long-term care home.

On May 21, 2020, during observation of a resident home area, Inspector #117 and # 756 observed PSW # 102 providing feeding assistance to a resident in room while not a wearing a mask. PSW #102 said that they had just come back from their lunch and forgotten to put on a mask. The PSW then went to a wall mounted Personal Protective Equipment (PPE) carrier, did not wash their hands, selected a face mask and put on the mask inside out. The PSW did not put on a face shield

The home's administrator and acting DOC stated that staff on the unit are to wear a mask and face shield at all times. Other PPEs, such as gloves and gowns, are to be used when providing direct resident care and in accordance with each resident's plan of care.

As such, PSW #102 did not participate in the implementation of the infection prevention and control program.
(117)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

2. As per Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 initially issued on March 22, 2020, and having regard to the immediate risk to residents of COVID-19 in long-term care homes and retirement homes, the necessary, present, and urgent requirement to implement additional measures for the protection of staff and residents, including, but not limited to, the active screening of residents, staff and visitors, active and ongoing surveillance of all residents, screening for new admissions, managing essential visitors, changes to when an outbreak of COVID-19 is declared at a home, including when it is over, and specimen collection and testing for outbreak management;

June 3, 2020, management staff #160 came to work at the LTC home and was screened at LTC home entrance for COVID-19. Later in the day, ADOC #101 asked hospital staff #125 to swab management staff #160 for COVID-19 as staff #160 was presenting with atypical symptoms of COVID-19. Hospital staff #125 said that management staff #160 had informed them that they had not reported their atypical symptoms at the time of their entrance screening.

On June 3, 2020, the licensee failed to ensure that management staff 106 participated fully in the implementation of IPAC. (Log #010694-20) (117)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

3. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Directive #3, dated April 15, 2020, for Long-Term Care homes under the Long-Term Care homes Act, 2007, states that long-term care homes should immediately ensure that all staff wear a surgical/procedural masks at all times. On June 24, 2020, staff member #174 was observed in the main office speaking with another staff member and staff member #174 was not wearing a procedural/surgical mask.

The severity of this issue was determined to be a level 3 as there was actual risk of harm to residents during an outbreak.
The scope was a level 1 as these were isolated incidents. The home has a level 2 Compliance History, with previous non-compliance to a different subsection.

• O.Reg. s. 88 (2): issued as a WN and LTCHA s. 15 (2) (a) as a VPC on January 7, 2020 under inspection # 2019_617148_0033
(756)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 114 (3)

The licensee shall:

1. Ensure that all registered nursing staff of the long-term care (LTC) home are re-educated on the licensee's policies related to self-administration of medication, subcutaneous medication infusions, reallocation of injectable products and to sharps handling
2. Conduct weekly audits to assess compliance with the home's written policies and protocols in relation to:
a. Residents within the LTC home self-administering medication
b. Preparation and administration of injectable medication
c. Discontinuation of medication and reallocation of medication
d. Sharps handling during medication administration
3. Document, implement and re-evaluate corrective actions to address any identified deficiencies while ensuring that lessons learned are incorporated into the quality improvement processes.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policies for the medication

management system are implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. (Log #010694-20)

Resident #022 is identified as having some cognitive impairments. On a specified day in 2020, inspector #117 observed that the resident had a medication at their bedside table. The prescription label indicated that the resident is to take a specified dosage up to 4 times a day, as needed, and that the medication can be left at the resident's bedside.

Inspector #117 spoke with the resident regarding the medication. When asked about the use of the medication, resident #022 could not provide information as to when they last took the medication and how many doses of the medication they have taken. The inspector also asked resident #022 if they informed the unit nursing staff when they had taken the medication. The resident said that they do not recall informing the unit nursing staff when they take the bedside medication. Resident #022 indicated that they keep the medication out in the open, on top of the bedside table, which is located at the room entrance.

A review of the resident's medication order was done with RN # 133 and RPNs #132 and #134. On a specified day in 2020, the resident's then attending physician, prescribed that two identified medication be at bedside for patient use as needed and for staff to review the instructions with the resident. It was also noted that thirteen (13) days later one medication order was reviewed and discontinued by the resident's new attending physician. However, the order for the other medication remained unchanged.

Further review of the eMAR for two identified months in 2020 indicate that the observed medication had been at the resident's beside since the day of the original prescription order. Its use was documented on two occasions on the eMAR. The eMARs also document that the discontinued medication was at the resident's bedside a total of 13 days. Its use was documented on one occasion.

RPNs #132 and #134 said that they were aware of the order to have the two prescribed medications at the resident's bedside as well as the presence of these medications at the resident's bedside. Both RPNs said that the resident has some cognitive impairments and that resident #022 has difficulties in providing information to nursing staff regarding their self-administration of the prescribed medications.

The DOC said to the inspector that they had recently been made aware that resident #022 had a prescription for a bedside medication. The DOC said that no medications are to be left at resident bedsides unless the residents had been assessed as to their ability to self-administer, as per the licensee's policy.

As such, the licensee's policy #RC-16-01-15 "Self-Administration of Medication" was not implemented.
(117)

2. The Pharmacy Policy and Procedure Manual for LTC Homes from Medical Pharmacies, the licensee's pharmacy services provider indicates the following : " 10-6 Subcutaneous Medication Infusion", dated 2 / 17,

"Once the desired quantity is drawn into the syringe, the remaining quantity should be discarded using procedures appropriate to medication (e.g. wasting of a monitored medication requires a witness and appropriate documentation). Do not save residual mediation for subsequent injections unless explicitly directed by administrative staff and/or manufacturer. The storage of opened ampoules with residual medication is not acceptable."

"The practice of saving the entire contents of an ampoule by drawing up multiple syringes for future injections is strongly discouraged and is generally considered to be unsafe practice except in 'dire circumstances' (e.g. drug shortages) and/or when explicitly directed by administrative staff and/or the manufacturer."

On a specified day in 2020, RPN #112 prepared a monitored injectable medication for residents #027 and #028. As per the Narcotic Monitoring Record (NMR), one ampoule of the identified medication was used to draw one dose for resident #027 and another dose for resident #028. The NMR documents that a certain dose of the medication was wasted. There is no witness signature to the wastage of the monitored medication on the NMR.

RPN #112 said to inspector #117 that they did prepare, by them self, both resident's medication, using the same ampoule, as they were concerned with possible medication shortage due to the COVID-19 outbreak in the home.

As per Pharmacist #177, the licensee has a policy regarding the use of injectable medication. No injectable medication ampoules are to be used to draw multiple medication dosages unless explicitly directed. Pharmacist #117 said that Medical Pharmacies did not provide any directives regarding the drawing of multiple doses from injectable medication ampoules during the licensee's COVID-19 outbreak.
(Log #010694-20)
(117)

3. On a specified day in 2020, a complaint was received stating that RN #153 did not follow proper needlestick handling procedure after providing an intramuscular injection of a medication to resident #035 on a specified day in 2020.

The Licensee's Sharps Handling Policy, #RC-25-01-44, last updated February 2017, defines a sharp as needles and syringes with needles attached. This policy states that the nurse is to ensure that sharps are not transported from the site of use for disposal and that following the administration of an injectable medication the nurse immediately deploy the safety engineered mechanism and then place the sharp in the puncture resistant container at site of use.

On a specified day in 2020, there is an administration record and progress note for a prescribed medication administered by intramuscular injection to resident #035 by RN #153.

Staff member #125 stated that after RN #153 administered a medication via intramuscular injection, RN #153 did not deploy the safety cap on the needle and exited the room. The ADOC #135 confirmed that RN #153 did not cap the needle immediately after administering the medication, and only capped the needle at the doorway of the room after another staff member yelled out to do this.

As such, the licensee's Sharps Handling policy was not implemented by RN 153 on a specified day in 2020. (Log #010764-20)

(756)

(A1)
4. The Pharmacy Policy and Procedure Manual for LTC Homes from Medical Pharmacies, the licensee's pharmacy services provider indicates the following : " REALLOCATION OF INJECTABLE PRODUCTS COVID-19 PANDEMIC EMERGENCY MEASURE (3/20)"

The policy states the following:

Action:
• Medications to be reallocated in the home are: Morphine, HYDROmorphone, Midazolam, Lorazepam, Haloperidol, Glycopyrrolate, Methotrimeprazine (Nozinan) and Scopolamine.

• Injectable products may only be reallocated within the home (not returned to pharmacy)
• The reallocation is ideally completed by a pharmacist (or physician) and Director of Care/Wellness (DOC/DOW), or registered staff delegate, for the duration of the pandemic only.
• In circumstances where a pharmacist or physician is not available, the DOC/ADOC and nurse may complete the reallocation.
• Proper documentation of the reallocated drug must be traceable and auditable (use Reallocation Log and Shift Counts)

Procedure:
Nurse:
1. Process discontinued orders as per standard nursing procedures followed in the home (i.e. place narcotic injectables in wooden narcotic destruction box). Pharmacist (or Physician) and DOC/DOW (or delegate) OR a DOC/DOW and a nurse:
2. Examine injectable products for tampering and ensure supply is not expired.
3. Complete proper documentation (for narcotic injectables) on the Drug Destruction and Disposal Narcotic and Controlled Substances form, however, do not destroy any of the injectable products.
- Document "Reallocated to ESB "and date next to any entry being reallocated from destruction.
- Add reallocated drug information and quantities to the Narcotic Shift Count sheet specifying this is a "Reallocated Supply".
4. Attach a new label to reallocated products:
- New label must include date, drug name, strength, lot #, expiry date, and a name line for entry of future resident name.
- New label must have Pharmacist/Physician or Nurse name and signature
5. Complete Reallocation Log (for all reallocated supply) and store Log with ESB
6. Transfer reallocated supply and store with the ESB as per standard procedure.
7. Homes that do not have an ESB or enough space in their current ESB, can assign another locked box or cupboard for storage of the reallocated medication and clearly label it "Reallocated Supply".

On a specified day in 2020, resident #040's monitored injectable medication was discontinued.

As per the Narcotic Monitoring Record (NMR), resident #040's discontinued monitored medication was used on the next day by RPN #112 to prepare prescribed medication and administer these to residents #027, #028 and #041. Three and five days later, this same discontinued medication was used by RPN #184 to prepare prescribed medication and administer these to residents #001 and #041. The discontinued monitored medication was not reallocated as per the policy to an identified emergency drug box, resident #040 identifiers were not removed from the medication nor was the medication identified and clearly labelled as "Reallocated Supply".

RPN #112 said to inspector #117 that they did use the discontinued medication of resident #040 to prepare prescribed medication for residents #027, #028 and #041. The RPN said that this was done as they were concerned with possible medication shortage due to the COVID-19 outbreak in the home. The DOC said that they had given directions to RPN #112 for the reallocation of the discontinued medication as they were concerned with possible medication shortage due to the COVID-19 outbreak in the home.

As per Pharmacist #177, the licensee's policy regarding the reallocation of discontinued monitored medication was not put into force during the COVID-19 outbreak. They communicated to the home's DOC and ADOC #119 on specified day, that to avoid any shortage of supplies, Medical Pharmacies needed to be informed when staff were removing the identified medication from the emergency supply and who they were using it for so that they could replace the medication the same day. They also communicated that to request refills and higher quantities of medication for residents who have active orders so that the registered nursing staff won't need to use the emergency drug box. Pharmacist #177 indicated that Medical Pharmacies had made deliveries of the identified monitored medication five days prior to the reallocation of medication. Three days later, Medical Pharmacies was informed that the LTC home's emergency drug box identified monitored medication had ran out the day before and pharmacy sent out a full amount of the medication in a special delivery to the home that day. As per the pharmacist, no request for the medication was received by the pharmacy between the two delivery dates. Pharmacist #117 said they nor their colleagues were advised or notified of the reallocation of resident #040's discontinued monitored medication on a specified day or thereafter.

As such, the licensee's policy on the reallocation of medication was not followed by

RPN #112, #184 and the DOC. (Log #010694-20)

The severity of this issue was determined to be a level 3 as there was actual risk of harm to residents.
The scope was a level 2 as this was a pattern of incidents. The home has a level 2 Compliance History, with previous non-compliance to a different subsection. Based on this, a Director Referral will be made in regard to O.Reg. s. 114 (3).

- O.Reg. s. 8 (1)b), s.135(2) and s.131 (1-2-3): issued as a VPCs on March 22, 2018 under inspection # 2018_627138_0002
- O.Reg. s. 8 (1)b): issued as a VPC on July 27, 2017 under inspection # 2017_682549_0002

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 11, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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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 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 26th day of August, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LYNE DUCHESNE (117) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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