Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 23, 2016	2016_267528_0010	016170-16	Resident Quality Inspection

Licensee/Titulaire de permis

SIX NATIONS OF THE GRAND RIVER
1745 Chiefswood Road P.O. Box 5000 Ohsweken ON N0A 1M0

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

IROQUOIS LODGE NURSING HOME
1755 Chiefswood Road P.O. Box 309 Ohsweken ON N0A 1M0

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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 30, 31, 2016 and June 1, 2, 3, 7, 8, 2016

This inspection was done concurrently with critical incident inspection log #'s: 003963-15, 029563-15, 034961-15 related to responsive behaviours, 016655-16 related to abuse, mandatory reporting log #001073-15, and follow up inspection log # 009866-15 related to abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Recreation Staff, Food Service Supervisor (FSS), Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), cooks, dietary aides, housekeeping staff, residents and families.

The inspectors also toured the home, observed care and services provided to residents and reviewed records including but not limited to: resident clinical health records, menus, staffing schedules, training records, meeting minutes, policies and procedures, program evaluations and investigation records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2015_240506_0008	585

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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 safe transferring and positioning devices or techniques were used when assisting the resident.

Review of the plan of care indicated that resident #011 fell in May 2016 and sustained an injury. Interview with the resident stated they were transferring from bed into their wheelchair when they slipped and fell. Interview with PSW #120 who was present at the time of the transfer, stated the resident was a one person limited assist for transfers. PSW #120 reported that they put the brakes on the wheelchair prior to the transfer and the resident transferred themselves; however, confirmed that the wheelchair moved which resulted in the resident falling. Interview and observation of the resident's wheelchair with the brakes fully engaged revealed the wheelchair would not move during a transfer. Interview with the Physiotherapy Assistant (PTA) stated that when the resident reached over to use the arm rest to help them transfer, the resident's weight and the fact that the brakes were not engaged would allow the wheelchair to move and this would have resulted in the resident losing their balance and falling. Interview with registered staff # 122 who completed the post falls assessment stated the resident was a one person limited assist for transfers in and out of bed and they observed the wheelchair had moved during the transfer. A safe transfer was not used when assisting the resident as the brakes of the wheelchair were not fully engaged which resulted in the resident falling and sustaining an injury. (581) [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 75. Screening measures

Specifically failed to comply with the following:

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

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that screening measures were conducted in accordance with the regulations before hiring staff and accepting volunteers.

Ontario Regulation 79/10, made under the Long-Term Care Homes Act, 2007, states under regulation 215. (2): the criminal reference check must be (b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.

Review of five recently hired staff files revealed two staff did not have criminal reference checks conducted and completed before they were hired. Dietary staff #116, in May 2015, did not have a criminal reference check completed until July 2015 ,and was not signed by the sergeant until August 2015. Activity staff #117, hired in October 2015, did not have a criminal reference check completed until November 2015. Interview with the Administrator confirmed some staff had been hired upon Human Resources only receiving a receipt of payment for a criminal reference check. The Administrator confirmed that although both staff criminal reference checks were acceptable as both had negative results, both were hired and worked in the home before their criminal reference checks were conducted. (585) [s. 75. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. The Resident Council Minutes from February, April and May 2016, indicated that residents brought forward concerns that scheduled baths were being missed when the home was short staffed; and Family Council Minutes from May 2016, identified concerns that residents were not getting bathed when staff were not replaced.

B. The plan of care for resident #017 identified that the resident required one to two staff assistance when bathing. During the course of the inspection, interviews with resident #17 identified that the resident did not always receive their scheduled bath or shower. Review of Point of Care (POC) bathing records from March to May 2016, did not include a documented bath at least twice a week, as required.
i. On two occasions in April 2016, PSW staff documented that the resident was not available for bathing and there were no documented baths that week.
ii. On three occasions in May 2016, PSW staff documented the resident did not receive their scheduled bath, and there was no documentation to support that a make up bath had occurred. Furthermore, on two separate days in May 2016, PSW # 104 documented the resident was not available for bathing. When PSW #104 was interviewed, they identified that they did not work the bath shift and did not bathe the resident. Interview with PSW #104 and #107 confirmed that residents sometimes missed their minimum scheduled baths due to water issues, staffing, or workload issues. (528)

C. The plan of care for resident #011 confirmed that the resident had two scheduled bathing days per week. In an interview with the resident in May 2016, they identified concerns that they did not always receive their scheduled bath or shower. Review of POC documentation identified that scheduled baths were not documented for nine days in March and April 2016, (revealing that two consecutive scheduled baths were missed). On one occasion in April 2016 and one in May 2016, the resident's scheduled bath was documented as not given and no make up bath was noted. Interview with PSW #107 who was usually responsible for bathing resident's when working, identified that if the home was short staffed, the PSWs responsible for bathing resident were moved to the floor and not able to complete bathing, they also identified water issues and workload as a cause for residents missing scheduled bathing days and not receiving them, at a

minimum, twice a week. (528)

D. Resident #016 reported that they did not always receive a bath twice a week. Review of their bathing record revealed they missed four baths in April and two in May. PSW #107 who regularly worked in the bath house reported when a resident did not receive a bath, they documented 'no'. PSW #107 reported two staff were assigned to work in the bath house; however, on some shifts they were the only staff working and as a result, unable to bathe all residents. PSW #107 reported they worked alone on two of the identified days in April 2016, and confirmed they did not bathe the resident on both days. Interview with PSW #108 who also provided baths reported at times they worked alone in the bath house due to staff shortages and were unable to bathe all residents, or was pulled from the bath house to work on the floor. PSW #108 reported staff would try to wash up residents through the day; however, it was not a complete bath. PSW reported they worked alone on the two identified days in May 2016, and were unable to bathe the resident, at a minimum, twice a week. (585)

E. Resident #013 reported that they did not always receive a bath twice a week. Review of their bathing record revealed they missed two baths in April and four in May. Interview with PSW #107 who regularly worked in the bath house reported when the resident declined a bath, they documented 'refused'; however, when they did not receive a bath, they documented 'no'. PSW #107 also reported two staff were assigned to work in the bath house; however, on some shifts they were the only staff working and as a result, unable to bathe all residents. Interview with PSW #108 and PSW #121 who worked in the bath house both reported at times they worked alone in the bath house due to staff shortages and were unable to bathe all residents, or were pulled from the bath house to work on the floor. PSW #108 reported staff would try to wash up residents through the day; however, it was not a complete bath and confirmed that resident #013 was not bathed, at a minimum, twice a week. (585) [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is bathed, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all drugs were stored in an area or a medication cart that was secure and locked.

On June 1, 2016, at 1138 hours, a medication cart in the I wing was observed in the hallway, unlocked for an unidentified period of time. The Long-Term Care Home's Inspector was able to open the drawers of the cart which contained resident medications without staff being aware. Registered staff #110 came out of a resident room, confirmed registered staff were to have access to the cart only; however, left the cart unlocked by mistake. (585) [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all drugs are stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

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

A. Resident #011 fell in May 2016 and sustained an injury. During the course of this inspection, the resident was observed wearing a device. Interview with PSW #120 stated that the resident was to wear the device at all times and was only removed for dressing. Review of the written plan of care and kardex did not indicate that the resident was to wear a device at all times due to the recent injury and this was confirmed by the RAI-MDS Coordinator. (581)

B. In March 2016, the MDS assessment for resident #020 identified that the resident required supervision with eating. Review of the written plan of care did not include the

level of assistance required for eating. Interview with RPN #110 confirmed that resident #020 needed supervision, reminder, and encouragement with drinking and assistance with opening small containers. On June 7, 2016, interview with MDS-RAI Coordinator confirmed that the resident's plan of care did not contain the planned care for the resident related to assistance with eating. (632) [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A. The Resident Assessment Protocols (RAP) from December 2015, for resident #020 indicated that the resident had no documented diagnosis of a specific disease. The RAP from March 2016, indicated that the resident had the diagnosis. Review of Minimum Data Set (MDS) Assessment; section I. Disease Diagnosis from December 2015 and March 2016, did not include the diagnosis. Interview with registered staff #105 confirmed that the resident had the diagnosis but it was not coded in the MDS assessment and therefore not included as a diagnosis in December 2015 and March 2016, MDS assessments. The RAP and MDS assessments from December 2015 and March 2016, for the resident #020 did not complement each other. (632)

B. In April 2016, an MDS assessment completed for resident #013 indicated they had an infection during the assessment period. Review of the progress notes did not reveal the signs or symptoms of infection. Interview with RAI-MDS Coordinator #100 confirmed they did not have an infection during the April 2016 assessment period. (585)

C. Resident #016's plan of care and MDS coding from April 2016, identified they were continent of bladder. Review of point of care documentation completed by PSWs and progress notes revealed the resident was incontinent of urine on seven occasions during the assessment review date (ARD) period in April. Interview with PSW #118 reported the resident had a history of a leaking medical device, and registered staff #109 also reported there were a few days in April when their device was leaking. Interview with the RAI Coordinator #100 confirmed the resident's assessments related to urinary continence did not match as the resident was occasionally incontinent of bladder, with incontinence occurring two or more times a week; however was coded as continent of urine. (585)

D. A review of the MDS assessment completed in December 2015, indicated resident

#018 was usually continent of bladder and the bowel and bladder assessment completed during the same time period, identified they were continent of bladder. Review of the MDS Assessment in March 2016, noted they were continent of bladder and there was no change in urinary continence between the two MDS assessments. Interview with the RAI-MDS Coordinator stated that the resident did have some incontinence with an improvement in the resident's urinary continence between December 2015 and March 2016 and confirmed that the MDS assessment and the bowel and bladder assessments in December 2015, were not consistent with each other. (581)

E. The Admission MDS Assessment in December 2015, for resident #014 coded the resident as having no pain. However, an admission note documented by registered staff documented that the resident had multiple areas of altered skin integrity that caused discomfort. Interview with RAI-MDS Coordinator confirmed that the resident often denied pain and showed non-verbal signs of pain related to multiple wounds. It was confirmed that the Admission MDS Assessment and registered staff admission assessment were not consistent with each other, in relation to identifying pain. (528) [s. 6. (4)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. Resident #011 fell in May 2016, and sustained an injury, Review of resident #011's written plan of care indicated they were transferred using an assistive device with one person constant supervision and physical assistance. Interview with the resident and Physical Therapist Assistant (PTA) stated that had not used the device for over six months and prior to their fall with injury, they were transferred with minimal assistance of one person. Interview with PSW #103 stated they were now transferred with two staff for all transfers. Interview with RAI MDS Coordinator confirmed that the plan of care was not reviewed and revised when the resident's care needs changed related to transfers.

B. Review of the written plan of care for resident #011 identified that staff were to set up the resident for dressing; however, the resident was capable of dressing themselves. Interview with the resident and PSW #120 stated they required two staff to assist in dressing due to pain and immobility. Interview with the RAI Coordinator confirmed that the resident did require more assistance with dressing and the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to have his or her personal health information kept confidential in accordance with that Act.

On an identified day in June 2016, a locked cabinet located across from the nurse's station included one Resident Quality Inspection Licensee Report and one Order Report from April 2015, which contained person health information of the residents. The Administrator stated that several staff had the key to open the cabinet if residents or families wanted to review the reports, and confirmed the Licensee Reports should not have been posted in the cabinet as it contained personal health information. [s. 3. (1) 11. iv.]

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 any plan, policy, procedure, strategy or system, was complied with.

A. The home's policy "Food Temperatures Policy: FNSFP052", effective date April 28, 2016, directed staff to record food temperatures before the food leaves the kitchen. Review of Production Sheets did not include temperature records on May 30 and 31, 2016, for supper meals. On June 1, 2016, interview with cook #113 and FSS confirmed that no temperatures were taken, as required in the home's policy. (632)

B. The homes policy "Bed Rails and Entrapment", created July 2015, directed staff to assess each resident for the need to use bed rails using the Bed Entrapment Assessment and the results of the assessment to be documented in the resident's plan of care.

During the course of the inspection, resident #014 was observed in bed with bed rails in the raised position. The written plan of care for resident #014 identified that the resident used both rails for bed turning and repositioning. The Bed Entrapment Assessment from December 2015, identified that the resident required the use of "the bed rail" but did not specify how many bed rails the resident used. Interview with the RAI Coordinator confirmed that the Bed Entrapment Assessment was incomplete and did not describe that the resident used both "short rails". (528)

Interview with MDS RAI Coordinator confirmed that the bed rails assessment from November 2015 was incomplete, and did not specify that the resident required two short rails; however, the document the home refers to as the written care plan was updated to include short rails for transferring and mobility. (538) [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During the course of this inspection residents were observed sitting outside at the front entrance as well as on the courtyard outside of the family room. During observations, the areas did not appear have a resident-staff communication and response system. Interview with the Administrator confirmed the outdoor area and courtyard, where residents used daily, did not include resident-staff communication and response systems. (581) [s. 17. (1) (e)]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was policy was complied with.

Included as part of the home's abuse policy, their process, "4.1.3 Investigation of Abuse", revised March 2016, stated "as soon as the Manager is aware of any allegation of resident abuse by staff, an investigation must be conducted. The staff should be interviewed and will provide a statement which will be documented."

In December 2014, the home received a written complaint from a resident's family regarding the care that was provided to the resident while they resided in the home. The letter identified concerns related to mistreatment of the resident by PSW #118. The letter stated the family informed registered staff #125 of the incident a few minutes after the alleged incident.

In an interview with PSW #118 on June 7, 2016, they identified they were aware of allegations and home's subsequent investigation; however, denied any mistreatment of the resident. On June 7, 2016, registered staff #125 was interviewed and did not recall the family reporting concerns to them regarding inappropriate care provided by staff of the home. The Administrator recalled allegations of alleged abuse and confirmed that an investigation was conducted immediately; however, there were insufficient grounds to substantiate abuse. The Administrator also confirmed that the home's policy outlined that a written record including written statements should have been made, which did not occur. (585) [s. 20. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses, and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

A. The home's procedure titled "Sanitation for Night Shift", identified that on Wednesdays staff were to use a water resistant marker to label all personal items located in resident's bathroom with their name.
i. During an initial tour of the home, two unlabelled combs were observed in the shower room, both appeared to be used. The combs were observed in the shower room approximately four days later. Interview with PSW #121 confirmed that the items were not labelled and discarded them.
ii. In May 2016, an unlabelled toothbrush and used bar of soap were observed in a shared resident's bathroom; and in resident #82's shared bathroom, an unlabelled used electric razor was observed. Interview with PSW #120 confirmed resident's personal items should be labelled. [s. 37. (1) (a)]

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 a resident exhibiting 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, when clinically indicated.

In December 2015, resident #014 was admitted to the home with three areas of altered skin integrity which required ongoing treatment.
i. On admission registered staff noted an area of altered skin integrity that required daily treatment. No weekly assessments were completed until two weeks later, at which time, registered staff documented the area as cleared.
ii. On April 24, 2016, registered staff assessed an open area, the area was measured and required treatment, but no weekly wound assessments were completed until four weeks later.
iii. From admission, a second wound was being treated and the following was not completed: weekly assessments for one week in December 2015, three weeks in January 2016, and two weeks in March 2016.
iv. The resident's third wound was being treated every other day and did not include weekly wound assessments for two weeks in January 2016, one week in February 2016, and two weeks in March 2016.
v. A new area of altered skin integrity, related to pressure, was noted in February and March 2016; no weekly wound assessment were completed.
vii. Although the resident had multiple areas of altered skin integrity related to pressure and remained at high risk for altered skin integrity, wounds were not consistently assessed weekly, as confirmed by the RAI Coordinator. (528) [s. 50. (2) (b) (iv)]

WN #12: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

On an identified day in June 2016, resident #011 identified that they had been provided with assistance with toileting and incontinent care before mealtime. After dinner, the resident was assisted with toileting and when they requested a new dry brief, PSW #104 refused, indicating that the brief was not wet and did not require a change. The resident stated to the Inspector, immediately after the incident, that the brief was uncomfortable and felt wet.
i. Interview with PSW #104 confirmed that although the resident had requested a new dry brief, a new brief was not provided to the resident as the brief appeared dry.
ii. Further discussion with PSW #104 confirmed that although the brief did not appear to be wet, the resident expressed discomfort, and after the interview, the brief was immediately changed and a small area of the wetness indicator had observed to be activated.
iii. Interview with the Administrator/DOC confirmed that the home's expectation would be for staff to ensure that residents are clean, dry and comfortable. It was also identified that continent care products are always available for staff and residents; therefore, the brief should have been provided to the resident on request.

On the identified day in June 2016, after mealtime, resident #011, who required continence care products, was not provided with sufficient changes to remain comfortable. (528) [s. 51. (2) (g)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of five per cent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #17 was identified at a high nutrition risk related to multiple comorbidities and eating decline, all affecting weight.
i. From March to April 2016, the resident lost weight. In April 2016, a referral was completed to the registered dietitian; however, review of the plan of care did not include any nutritional assessments related to the weight loss. In June 8, 2016, interview with FSS confirmed that no nutritional assessment was recorded in the resident's plan of care related to the resident's weight loss in April 2016. On June 10, 2016, interview with the RD confirmed there was no documentation to support a nutrition assessment was completed related to the referral submitted in April 2016, related to the weight loss for resident #17.
ii. From April to May 2016, the resident had a large weight gain; however, review of the plan of care did not include any nutritional assessments related to weight gain or loss. On June 3, 2016, interview with RN #105 confirmed that registered staff members weighed the residents on weigh chairs, if a resident has a loss or gain weight of two kilograms (kg) over one month, the referral to the RD was to be completed. On June 8, 2016, interview with FSS confirmed that no nutritional assessment was recorded in the resident's plan of care related to the resident's weight gain in May 2016. On June 8, 2016, interview with the RD confirmed that re-weigh was not documented in the resident's plan of care and no referral was submitted to the RD, related to the weight gain in May 2016 for resident #17. (632) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure the food production system, at a minimum, provided standardized recipes and production sheets for all menus.

A. On June 1, 2016, during breakfast, resident #017 shared their well-done breakfast sausages with resident #015. Resident #015 reported that theirs were undercooked. Review of the recipes binder did not include a recipe for breakfast sausages (specifically, cook time and cook temperature) served on June 1, 2016. On June 1 and 3, 2016, interviews with the morning cook #114 and Food Service Supervisor (FSS) confirmed that there were no standardized recipe available for breakfast sausages.

B. From June 6 to 12, 2016, no production sheets were available for the following menu items on "menu week two":

i. On June 6, 2016, Peach Salsa was not included in the production sheet as a part of Spicy Pork Loin Sandwich with Peach Salsa meal served for supper. On June 6, 2016, interview with cook #113 and FSS confirmed that no Peach Salsa was included in the production sheet.
ii. On June 7, 2016, no production sheets for breakfast (cream of wheat, omelet, buttered whole wheat toast, banana, cold assorted cereal with bran, buttered raisin toast) and for lunch (tilapia(whitefish) coconut crumb, paprika seasoned potatoes, green beans with parmesan and lemon, summer berry flan, honey garlic meatballs, rice pilaf, mixed vegetables-montego mix, baked apples) were available. On June 7, 2016, interview with the cook #113 confirmed that no production sheets were available, which was also confirmed by FSS. (632) [s. 72. (2) (c)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who had received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, including but not limited to, the home's policy to promote zero tolerance of abuse and neglect.

Review of the home's staff training records from 2015 identified that only 55 out of 62 staff members, or 88% of staff, had received training on the home's policy to promote zero tolerance of abuse and neglect of residents. Interview RPN #119 and #126 confirmed that training was provided to staff through in-services, and it was a challenge to ensure 100% of staff were trained

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WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations which included the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, an explanation of the duty under section 24 to make mandatory reports, copies of inspection reports from the past two years for the long-term care home and orders made by an Inspector or the Director with respect to the long-term care home that were in effect or that have been made in the last two years.

During the course of this inspection it was noted that the home's policy to promote zero tolerance of abuse and neglect of residents and an explanation of the duty under section 24 to make mandatory reports was not posted. A review of the inspection reports that were posted in a locked cabinet by the nurses station revealed that the Resident Quality Inspection (RQI) public inspection report and public order report for 2015, with orders were not posted, as confirmed by the Administrator. (581) [s. 79. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received training annually in the area of falls prevention and management.

Information provided by the home indicated 17 percent of direct care staff received training in falls prevention and management in 2015 and this was confirmed by registered staff #119. (581) [s. 221. (1) 1.]

2. The licensee failed to ensure that all staff who provided direct care to residents received annual training provided for in the area of skin and wound care.

Review of the home's education training records identified that only 13 out of 41 staff received new staff orientation, which included skin and wound care. No other training records related to skin and wound were provided by the home. Interview with registered staff #126 confirmed that skin and wound training was included at monthly skin and wound committee meetings, for the committee, but did not include all direct care staff. (528) [s. 221. (1) 2.]

WN #18: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and that the symptoms were recorded.

Resident #010 exhibited symptoms of infection in March and April 2015. Review of the plan of care identified that the resident was not monitored and their symptoms were not documented on every shift. Interview with registered staff #119 confirmed that staff did not monitor and document resident #010's symptoms on every shift. (581) [s. 229. (5)]

Issued on this 13th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2016_267528_0010
Log No. / Registre no:	016170-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 23, 2016
Licensee / Titulaire de permis :	SIX NATIONS OF THE GRAND RIVER 1745 Chiefswood Road, P.O. Box 5000, Ohsweken, ON, N0A-1M0
LTC Home / Foyer de SLD :	IROQUOIS LODGE NURSING HOME 1755 Chiefswood Road, P.O. Box 309, Ohsweken, ON, N0A-1M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lori Davis Hill

To SIX NATIONS OF THE GRAND RIVER, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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.

Order / Ordre :

The licensee shall ensure:
i. Staff use safe transferring and positioning techniques with all residents as identified in their written plan of care prior to transferring the resident.
ii. Re-education is provided to all direct care staff on transferring and positioning techniques for all residents related to safe transferring, with specific focus on application of brakes on beds and wheelchairs.
iii. All staff are following the plan of care for all residents, especially in relation to transferring, using methods and/or devices residents are assessed to require as per the home's requirements.

Grounds / Motifs :

1. A. The non-compliance issued was determined to have a severity of 'actual harm/risk' with a scope of 'isolated'.

B. The licensee failed to ensure safe transferring and positioning devices or techniques were used when assisting the resident.

Review of the plan of care indicated that resident #011 fell in May 2016 and sustained an injury. Interview with the resident stated they were transferring from bed into their wheelchair when they slipped and fell. Interview with PSW #120 who was present at the time of the transfer, stated the resident was a one person limited assist for transfers.
PSW #120 reported that they put the brakes on the wheelchair prior to the transfer and the resident transferred themselves; however, confirmed that the wheelchair moved which resulted in the resident falling. Interview and observation of the resident's wheelchair with the brakes fully engaged revealed the wheelchair would not move during a transfer. Interview with the Physiotherapy Assistant (PTA) stated that when the resident reached over to use the arm rest to help them transfer, the resident's weight and the fact that the brakes were not engaged would allow the wheelchair to move and this would have resulted in the resident losing their balance and falling. Interview with registered staff # 122 who completed the post falls assessment stated the resident was a one person limited assist for transfers in and out of bed and they observed the wheelchair had moved during the transfer. A safe transfer was not used when assisting the resident as the brakes of the wheelchair were not fully engaged which resulted in the resident falling and and sustaining an injury. (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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