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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 6, 2015	2015_346133_0001	O-000581-14	Follow up

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

PETER D. CLARK CENTRE
9 MERIDIAN PLACE OTTAWA ON K2G 6P8

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 14th and 15th, 2015

This follow up inspection was in relation to a Compliance Order (CO #002) issued to the home as a result of the Resident Quality Inspection that occurred in June 2014. The Compliance Order was issued as a result of non compliance related to door alarms and doors that lead to non-residential areas.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Managers of Resident Care, the Facility Manager, the Manager of Recreation, Leisure and Volunteer Services, the Program Administration Clerk, registered and non registered nursing staff, a dietary aid, an identified resident, and an identified visitor.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s.9 (1) 1. (i) in that the licensee has failed to ensure that all resident accessible doors leading to stairways, and all resident

accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, are kept closed and locked.

This is specifically related to the main exit/entrance door for the building known as the Houses.

The main entrance/exit of the building known as the Houses consists of two sets of sliding doors that lead to the outside of the home. When exiting the building a person would first exit through the inner sliding door by using an access key card that activates the automatic opening function. Alternately, staff at the reception desk can cause the door to open remotely. Once past the inner door and within the vestibule, the outer sliding door will open automatically by motion detection. Neither one of these doors is alarmed as prescribed by O. Reg. 79/10, s. 9 (1) 1. iii. This non-compliance has been addressed within this inspection report. The licensee is required to ensure that one of these doors is alarmed as prescribed. In addition to a lack of an alarm, on January 15th, 2014, Inspector #133 observed that neither door was locked. The inner door is equipped with a thumb lock only and there is no lock of any kind on the outer exit door. During discussion, at the entrance area, the Administrator explained to the Inspector that the thumb lock is engaged to lock the inner door at approximately 11pm each night. The inner door is unlocked at 8am, when the Program Admin Clerk (PAC, staff # S103) arrives for the day. The Inspector demonstrated to the Administrator how they could slide the door open. It was agreed that the door was not locked and confirmed that there is no other locking mechanism on the door. Once through the inner exit door, in the vestibule, the outer exit door opens automatically. If the inner door is slid open, even slightly, it does not close automatically and there is no alarm to notify staff that the door is not fully closed.

Later that day, the Inspector spoke with the PAC and asked if they ever see people trying to slide the door open. The PAC indicated that every so often, such as every two months, they notice someone, such as a visitor or a person who has come in for an interview, trying to slide it open. She explained that she stops them before the slide it all the way open, as it is her understanding that manually sliding it open could damage the door, and then informs them of the proper way to exit.

It is noted that the reception desk does not face the door, and as such does not offer visual access to the immediate area in front of the inner exit door. There is a video camera, within the reception area, that allows the PAC a view of the area immediately

outside of the outer exit door. This allows them to verify who may be calling to come into the home.

This non compliance is widespread as it presents a potential risk to the majority of residents within the Houses building. [s. 9. (1)]

2. The licensee failed to comply with O. Reg 79/10, s.9 (1) 1. (iii) in that the licensee has failed to ensure that all resident accessible doors leading to stairways, and all resident accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, are equipped with an audible door alarm that allows calls to be canceled only at the point of activation AND is connected to the resident-staff communication and response system, OR is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

This is specifically related to the front door of both buildings. As well, this is related to the fact that stairway door alarms can be cancelled remotely, from the City of Ottawa Corporate Security Operations Center, that is located at 101 Center Point Drive .

Peter D. Clark consists of two buildings, known as the Houses and the Bungalows.

Within the building known as the Houses, there are 4 resident areas (Pine, Elm, Maple and Willow houses). On each house there are two sides (east and west side); on each side there are two doors, one down each hallway, that lead to stairways. Between the four houses, there are a total of 16 doors that are accessible to residents that lead to stairways.

As a result of the home's Resident Quality Inspection, conducted in June 2014, it was identified, by Inspector #148, that the stairway doors referenced above were not alarmed. As a result of the lack of alarms at these doors and at main exit doors in both buildings, and non-compliance related to doors that lead to non-residential areas, Compliance Order # 002 was served to the licensee on June 25th, 2014. The compliance date for CO #002 was December 22, 2014.

On January 14th and 15th, 2015, Inspector #133 conducted a follow up inspection to verify that the stairway doors had been alarmed as required. Inspector #133 found that the doors were now equipped with an audible alarm, and that the door alarms were connected to the resident-staff communication and response system. The Inspector

learned that in order to cancel a sounding alarm, a staff person is supposed to swipe their ID card at the card reader, at the door. On January 15th, 2015, Inspector #133 found that they were unable to cancel the stairway door alarms by swiping staff ID cards that they had been provided with. In consultation with the home's Facility Manager (FM), staff # S100, while testing the door alarms in the Maple House unit, it was discovered that the process to map staff ID cards to the card readers at the stairway doors had never occurred. At that time, only the FM's ID card was able to cancel the alarms. The Inspector proceeded to test stairway door alarms in the Elm House unit, and the FM assigned the home's Facility Operator (FO), staff # S101, to assist the Inspector to turn off the sounding alarm following activation. As testing proceeded, the FO had to call the City of Ottawa Corporate Security Operations Center, and requested they remotely cancel the sounding alarms. The FO was in communication with the City of Ottawa's Supervisor of Security Operations Center (SSOC), staff # S102. The Inspector asked the FO to clarify how the SSOC was able to cancel the alarms remotely. The SSOC communicated that in order to do so, they use the access control monitoring software and deactivate the alarm relay.

The identified stairway doors were found not to be compliant because the audible alarm can be cancelled remotely. As per O. Reg. 79/10, s. 9 (1) 1. iii, such doors are to be equipped with an audible alarm that allows calls to be canceled only at the point of activation. The point of activation is the door.

As a result of the home's Resident Quality Inspection, conducted in June 2014, it was identified, by Inspector #148, that the main entrance/exit doors, in both buildings, were not equipped with an alarm. As a result of this, a lack of alarms at stairway doors, and non-compliance related to doors that lead to non-residential areas, Compliance Order # 002 was served to the licensee on June 25th, 2014. The compliance date for CO #002 was December 22, 2014.

On January 14th, 2015, Inspector #133 began a follow up inspection to verify that the doors in question had been alarmed as prescribed by the legislation. Following discussion with the home's Facility Manager (FM) and Administrator on January 14th, 2015, it was revealed that neither door had been alarmed. No corrective actions had been taken in relation to these doors. The home's Administrator indicated that it had not been understood that these doors required alarms.

This widespread non compliance related to door alarms presents a potential risk to the residents of the home. [s. 9. (1)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 2 in that the licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

As a result of the home's Resident Quality Inspection, conducted in June 2014, it was identified, by Inspector #148, that on June 12, 2014, the clean and soiled utility rooms within the Pine House unit were closed but not locked, nor were they being supervised at the time. The doors were equipped with locks. As a result of this and non-compliance related to the absence of audible alarms on stairway doors in the Houses and on the main exit doors for both buildings, Compliance Order # 002 was served to the licensee on June 25th, 2014. The compliance date for CO #002 was December 22, 2014.

On January 14th, 2015, Inspector #133 began a follow up inspection to verify if all doors leading to non-residential areas, that are not under the supervision of staff, were being kept closed and locked. Inspector #133 first proceeded to the Maple House (MH) unit. Upon arrival to the east side, at 11:42, it was observed that the door into the servery, from within the dining room, was closed but not locked. Several residents, in their wheelchairs, were seated at tables and 11 residents were sitting in the lounge in the immediate area of the dining room. There was no staff in the area supervising the door or supervising the residents. The Inspector proceeded into the servery and noted there was no staff present. The servery was observed to be a fully equipped servery with all of the usual industrial food service equipment and surfaces. The Inspector noted a door on the other side of the servery, went through it, and discovered it lead to the dining room on the west side of the MH unit. Residents were seated at tables and in the lounge in the immediate area. There was no staff in the area upon the Inspector's arrival, but a Personal Support Worker (PSW), staff # S104, arrived within moments. The Inspector asked the PSW if the servery door is always kept unlocked. The PSW told the Inspector that it is, because if nursing staff need to get snacks or drinks for residents when dietary staff are not in the servery, they need access. At 11:50am, the Inspector went back through the servery, to the east side of the unit. The Inspector met a PSW, staff # S105, in the dining room. They were heating up food in the microwave at the time. The Inspector asked the PSW if the doors into the servery are always kept unlocked. The PSW said that normally, the doors would be locked when there is no one in the servery, but that sometimes it is not locked, and that nursing staff have a key if it is locked and they need access. The PSW then took her food out of the microwave and left the area. The Inspector watched the PSW go into the nearby staff room and shut the door. This again left the unlocked door into the servery unsupervised and residents sitting within the

area unsupervised. At 12:01 pm, the Inspector met a Dietary Aid (DA), staff # S106, in the east MH dining room. The Inspector asked the DA if the doors into the servery are always kept unlocked. The DA asserted to the Inspector that both doors, from the east and west side, had been locked by her when she left for her lunch break at 11:30am. The DA said that everyone has a key and that they don't always lock the doors after they open them. The DA asserted she was aware of the need to ensure the doors into the servery are kept locked when the servery is not attended. The Inspector went back over to the west side of the unit and asked the PSW, staff # S104, if they had a key to the servery and they replied that they did. Later that afternoon, in discussion with the home's Facility Manager (FM, staff #S100) and the home's Manager of Recreation, Leisure and Volunteer services (staff # S107), it was clarified that the PSWs do not all have a key into the servery, but that there is a key on the unit, likely kept within the nurse station.

Following observations of the unsecured servery doors and discussions with unit staff, still within the MH unit, east side, Inspector #133 proceeded to observe doors to non-residential areas. Around the corner from the dining room area, the Inspector found room #N246. A sign on the door indicated it was a biomedical waste storage room. The door was closed. At 12:05 pm, the Inspector pushed on the door and it opened. Within the room, the Inspector did not find biomedical waste. The Inspector found boxes of medical examination gloves, boxes of continence briefs, empty sharps/biomedical waste containers and pails. There was no staff in the area supervising the door or supervising rsidents in the area. 11 residents were seated in the lounge, around the corner from the room. At 12:12 pm, the FM met the Inspector in the immediate area of room #N246. The FM explained that following the Resident Quality Inspection in June 2014, where issues were identified with doors leading to non-residential areas, doors such as the one leading into room #N246 were equipped with new door hardware. He demonstrated that this door has a closer on it, a mechanism that ensures the door closes on its own after its been opened. As well, he demonstrated that the door handle is always locked. Staff can use their key to open the door, but they can never unlock it. The Inspector showed the FM how the door could simply be pushed open. The FM speculated that this was a result of the fact that the door closing mechanism was adjusted in the summer, when the wooden door frame may have been swollen, and now that it was winter, readjustment appeared to be required. It was noted that the door closing mechanism was not closing the door fully, so the locking mechanism was unable to latch. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 3 (13) in that in the name of outbreak control, the exit door of a care unit was kept closed and locked and residents were not provided with the means to exit independently. This served as a form of restraint for all residents of the identified unit. As well, the licensee failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 3 (14) in that a resident's right to receive visitors was not respected.

On January 14th, 2014, Inspector #133 arrived at the home to conduct a follow up inspection. The Inspector noted that there was a sign posted at the front entrance, related to an outbreak of respiratory illness at the home. The sign read "ATTENTION! WILLOW HOUSE is experiencing a RERSPIRATORY OUTBREAK. Residents are NOT to leave the unit until the outbreak is declared over. Visitors: We discourage visitors at

this time. If you feel you must visit, please speak to the charge nurse before visiting. Thank you kindly". The word NOT was in bold print as well as capital letters. On that day, the respiratory outbreak became active in the Pine House unit as well. At 4:58, the Inspector entered the Pine House unit, east side, and spoke with a Registered Practical Nurse (RPN), staff #S108. It was noted that a sign, as noted above, was affixed at the entrance to the unit. The Inspector asked the RPN about the sign, and asked if it really was the case that residents were not being allowed to leave the unit. The Inspector gave an example of a scheduled birthday party celebration that was to occur outside of the home. The RPN explained to the inspector that residents were not allowed off the unit for any reason. The RPN explained they had to control the residents' movement in order to prevent the possible spread of the respiratory illness out into the community, and to prevent further illness from coming into the unit. The door to this unit was closed and locked, requiring use of a swipe card for access. The Inspector did not have a swipe card, and required assistance from the RPN to exit the unit. Residents do not have swipe cards.

The Pine House Unit is not a secured unit. Locking these doors and not providing swipe cards to the residents of the unit serves to restrain them. As per the LTCHA, 2007, S.O. 2007, c.8, s. 30 (1) 5, restraining residents by use of barriers, locks or other devices or control, from leaving a room or any part of the home is not permitted. There are some exceptions to this provision which are not applicable in this situation.

On January 15th, 2015, at 11am, the Inspector was back at the home and in the immediate area of the reception desk in the Houses building. The Inspector observed the following: a person came in and informed the Program Admin Clerk (PAC, staff # S103) that she was going in to see her friend in the Willow Unit (resident #001) and would be taking them out for lunch. The PAC informed the visitor that this would not be possible, because the unit was in outbreak. The PAC advised that next time, they could call ahead and verify if there was an outbreak, so as not to waste a trip into Ottawa. The visitor turned to leave, and the Inspector asked if they could take a few minutes to talk with the Inspector. Concurrently, a Registered Nurse (RN) from the willow Unit, staff # S109, arrived on the scene. The RN recognized the visitor and confirmed that she couldn't go into the unit and that the resident could not leave the unit to go out for lunch. The Inspector asked the RN if it was truly the case that visitors were not being allowed into the Willow unit, and she confirmed again that visitors were not being allowed in. The RN and the PAC both informed the Inspector that it was a Program Manager for Resident Care, staff #S109, who had implemented this restriction. The Inspector then went and met with both of the home's Program Managers for Resident Care, #S109 and

#S110.The Inspector shared with both Program Managers what had occurred. They were both visibly upset. They explained that they are well aware that residents have the right to receive visitors, regardless of outbreak status, and that residents have the right to leave their units if they want to. In the name of outbreak control, the explained further, visitors have been asked to reconsider visiting and residents are asked to reconsider leaving their units. They confirmed that there is no quarantine order in place for the home. A quarantine order, issued by the local Medical Officer of Health, is the only way that the home could legally justify not allowing residents to leave their units. The Program Managers felt that there must have been a miscommunication about outbreak control measures that were put into place.

At 3:09pm on January 15th, Inspector #133 went into the Willow House unit to meet with resident #001. The Inspector found the resident seated in the front lounge. The Inspector explained to the resident that their friend had been there earlier that day and had wanted to see them and take them out for lunch, but they had not been allowed to do so. Resident #001 said that they would have really liked to see their friend and to go out for lunch. They said they hadn't seen their friend in a long time. Resident #001 indicated that they were not sick. Resident #001 asked the Inspector if they would make sure that staff knew that their friend was allowed in to see them and that they are allowed to go out for lunch with their friend. On the way out of the unit, the Inspector spoke with assembled unit staff in the nurse station, and advised them of resident's rights to receive visitors and of their right to leave the unit for an outing, with a visitor. The Inspector later ascertained that the outbreak of respiratory illness was first declared on December 28th, 2014.

It is noted that Willow House is a secured unit, for residents who require such an environment. It is therefore the norm for this unit that the doors into the east and west sides are kept closed and locked at all times. It is not the norm that residents are denied the right to leave the unit accompanied by a visitor for an outing.

On January 29th, 2015, the Inspector was provided with a door access report for the Pine unit east and west access doors, for the time frame spanning from January 11th, 2015 to January 17th, 2015. This report was provided to the Inspector by one of the City's corporate security advisors, staff # S111. This report shows the time that a secured door is accessed by a person carrying as ID badge swipe card. This report confirms that the Pine House unit east side door was closed and locked at the time of the Inspector's observation. Furthermore, this report illustrates that the east side unit door was closed and locked as of 12:50pm on January 14th, 2015 and that this doors were last accessed with a swipe card at 12:30am on January 15th, 2015. Keeping with the east side door,

the report illustrates that it was again closed and locked as of 4:19pm on January 15th, 2015 and that this door was last accessed with a swipe card at 11:03 pm on January 15th, 2015. The report also illustrates that the west side unit door was also closed and locked, as of 2:24pm on January 14th, and that this doors was last accessed with a swipe card at 12:17 am on January 15th, 2015. [s. 3. (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 with the requirement that all resident's right to receive visitors is fully respected and promoted, and that all resident's right not to be restrained, except in limited circumstances provided for under this Act and subject to the requirements provided for under this Act, are fully respected and promoted, to be implemented voluntarily.

Issued on this 6th day of February, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2015_346133_0001
Log No. / Registre no:	O-000581-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 6, 2015
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	PETER D. CLARK CENTRE 9 MERIDIAN PLACE, OTTAWA, ON, K2G-6P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	NOREEN LANGDON

To CITY OF OTTAWA, 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. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee will ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

This includes, but is not limited to, doors identified to be in issue during the inspection. Specifically, the servery doors in the Maple House unit and the door into room #N246 within the Maple House unit.

The licensee must audit all applicable doors, within both buildings, and ensure they are kept closed and locked when not supervised, in order to achieve sustained compliance with this requirement.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 2 in that the licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

As a result of the home's Resident Quality Inspection, conducted in June 2014, it was identified, by Inspector #148, that on June 12, 2014, the clean and soiled utility rooms within the Pine House unit were closed but not locked, nor were they being supervised at the time. The doors were equipped with locks. As a result of this and non-compliance related to the absence of audible alarms on stairway doors in the Houses and on the main exit doors for both buildings, Compliance Order # 002 was served to the licensee on June 25th, 2014. The compliance date for CO #002 was December 22, 2014.

On January 14th, 2015, Inspector #133 began a follow up inspection to verify if all doors leading to non-residential areas, that are not under the supervision of staff, were being kept closed and locked. Inspector #133 first proceeded to the Maple House (MH) unit. Upon arrival to the east side, at 11:42, it was observed that the door into the servery, from within the dining room, was closed but not locked. Several residents, in their wheelchairs, were seated at tables and 11 residents were sitting in the lounge in the immediate area of the dining room. There was no staff in the area supervising the door or supervising the residents. The Inspector proceeded into the servery and noted there was no staff present. The servery was observed to be a fully equipped servery with all of the usual industrial food service equipment and surfaces. The Inspector noted a door on the other side of the servery, went through it, and discovered it lead to the dining room on the west side of the MH unit. Residents were seated at tables and in the lounge in the immediate area. There was no staff in the area upon the

Inspector's arrival, but a Personal Support Worker (PSW), staff # S104, arrived within moments. The Inspector asked the PSW if the servery door is always kept unlocked. The PSW told the Inspector that it is, because if nursing staff need to get snacks or drinks for residents when dietary staff are not in the servery, they need access. At 11:50am, the Inspector went back through the servery, to the east side of the unit. The Inspector met a PSW, staff # S105, in the dining room. They were heating up food in the microwave at the time. The Inspector asked the PSW if the doors into the servery are always kept unlocked. The PSW said that normally, the doors would be locked when there is no one in the servery, but that sometimes it is not locked, and that nursing staff have a key if it is locked and they need access. The PSW then took her food out of the microwave and left the area. The Inspector watched the PSW go into the nearby staff room and shut the door. This again left the unlocked door into the servery unsupervised and residents sitting within the area unsupervised. At 12:01 pm, the Inspector met a Dietary Aid (DA), staff # S106, in the east MH dining room. The Inspector asked the DA if the doors into the servery are always kept unlocked. The DA asserted to the Inspector that both doors, from the east and west side, had been locked by her when she left for her lunch break at 11:30am. The DA said that everyone has a key and that they don't always lock the doors after they open them. The DA asserted she was aware of the need to ensure the doors into the servery are kept locked when the servery is not attended. The Inspector went back over to the west side of the unit and asked the PSW, staff # S104, if they had a key to the servery and they replied that they did. Later that afternoon, in discussion with the home's Facility Manager (FM, staff #S100) and the home's Manager of Recreation, Leisure and Volunteer services (staff # S107), it was clarified that the PSWs do not all have a key into the servery, but that there is a key on the unit, likely kept within the nurse station.

Following observations of the unsecured servery doors and discussions with unit staff, still within the MH unit, east side, Inspector #133 proceeded to observe doors to non-residential areas. Around the corner from the dining room area, the Inspector found room #N246. A sign on the door indicated it was a biomedical waste storage room. The door was closed. At 12:05 pm, the Inspector pushed on the door and it opened. Within the room, the Inspector did not find biomedical waste. The Inspector found boxes of medical examination gloves, boxes of continence briefs, empty sharps/biomedical waste containers and pails. There was no staff in the area supervising the door or supervising residents in the area. 11 residents were seated in the lounge, around the corner from the room. At 12:12 pm, the FM met the Inspector in the immediate area of

room #N246. The FM explained that following the Resident Quality Inspection in June 2014, where issues were identified with doors leading to non-residential areas, doors such as the one leading into room #N246 were equipped with new door hardware. He demonstrated that this door has a closer on it, a mechanism that ensures the door closes on its own after its been opened. As well, he demonstrated that the door handle is always locked. Staff can use their key to open the door, but they can never unlock it. The Inspector showed the FM how the door could simply be pushed open. The FM speculated that this was a result of the fact that the door closing mechanism was adjusted in the summer, when the wooden door frame may have been swollen, and now that it was winter, readjustment appeared to be required. It was noted that the door closing mechanism was not closing the door fully, so the locking mechanism was unable to latch.

(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_362138_0009, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

#1 - The licensee will ensure that all resident accessible doors that lead to stairways, and all residents accessible doors that lead to the outside of the

home, with the exception of doors that lead to secure outside areas that preclude exit by a resident, including balconies and terraces, are equipped with alarms. As prescribed, each of these doors are to be equipped with an audible door alarm that allows calls to be cancelled ONLY at the point of activation and, A. is connected to the resident-staff communication and response system, or B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

This is to include doors that were identified to be in issue during the inspection. Specifically, the main exit doors of each building and the stairway doors in the Houses building. At each exit, one of the two doors is to be alarmed as prescribed. The alarm must be on the door that is locked, as prescribed.

The licensee will ensure that staff within the City of Ottawa Corporate Security Operations Centre, or any other staff in any other off-site location, do not have the ability to cancel a sounding alarm at any of the home's applicable doors. The licensee must prepare documented proof of such and must have this available at the home, for review upon the follow up inspection. Signatories to this document must include the person(s) with ultimate authority for the Corporate Security Operations Centre, as well as any other site from which the home's door alarms can be cancelled. The licensee must ensure that specific details as to how the ability to cancel alarms remotely using the Kantech security software, and any other applicable software, has been disabled, is included in the required documentation.

Until such time that all applicable doors are alarmed as is prescribed, the licensee is to implement measures that will ensure the safety of all residents. If an extension to the compliance date is requested, the licensee will be asked to submit supporting documentation that includes the safety measures.

#2 - The licensee will ensure that all resident accessible doors that lead to the outside of the home, with the exception of doors that lead to secure outside areas that preclude exit by a resident, including balconies and terraces, are kept closed and locked at all times. This is to include doors that were identified to be in issue during the inspection, specifically, the main exit door in the Houses building.

Until such time as the main exit door in the Houses building is locked, the licensee is to implement measures that will ensure the safety of all residents. If

an extension to the compliance date is requested, the licensee will be asked to submit supporting documentation that includes the safety measures.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg 79/10, s.9 (1) 1. (iii) in that the licensee has failed to ensure that all resident accessible doors leading to stairways, and all resident accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, are equipped with an audible door alarm that allows calls to be canceled only at the point of activation AND is connected to the resident-staff communication and response system, OR is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

This is specifically related to the front door of both buildings. As well, this is related to the fact that stairway door alarms can be cancelled remotely, from the City of Ottawa Corporate Security Operations Center, that is located at 101 Center Point Drive .

Peter D. Clark consists of two buildings, known as the Houses and the Bungalows.

Within the building known as the Houses, there are 4 resident areas (Pine, Elm, Maple and Willow houses). On each house there are two sides (east and west side); on each side there are two doors, one down each hallway, that lead to stairways. Between the four houses, there are a total of 16 doors that are accessible to residents that lead to stairways.

As a result of the home's Resident Quality Inspection, conducted in June 2014, it was identified, by Inspector #148, that the stairway doors referenced above were not alarmed. As a result of the lack of alarms at these doors and at main exit doors in both buildings, and non-compliance related to doors that lead to non-residential areas, Compliance Order # 002 was served to the licensee on June 25th, 2014. The compliance date for CO #002 was December 22, 2014.

On January 14th and 15th, 2015, Inspector #133 conducted a follow up inspection to verify that the stairway doors had been alarmed as required. Inspector #133 found that the doors were now equipped with an audible alarm, and that the door alarms were connected to the resident-staff communication

and response system. The Inspector learned that in order to cancel a sounding alarm, a staff person is supposed to swipe their ID card at the card reader, at the door. On January 15th, 2015, Inspector #133 found that they were unable to cancel the stairway door alarms by swiping staff ID cards that they had been provided with. In consultation with the home's Facility Manager (FM), staff # S100, while testing the door alarms in the Maple House unit, it was discovered that the process to map staff ID cards to the card readers at the stairway doors had never occurred. At that time, only the FM's ID card was able to cancel the alarms. The Inspector proceeded to test stairway door alarms in the Elm House unit, and the FM assigned the home's Facility Operator (FO), staff # S101, to assist the Inspector to turn off the sounding alarm following activation. As testing proceeded, the FO had to call the City of Ottawa Corporate Security Operations Center, and requested they remotely cancel the sounding alarms. The FO was in communication with the City of Ottawa's Supervisor of Security Operations Center (SSOC), staff # S102. The Inspector asked the FO to clarify how the SSOC was able to cancel the alarms remotely. The SSOC communicated that in order to do so, they use the access control monitoring software and deactivate the alarm relay.

The identified stairway doors were found not to be compliant because the audible alarm can be cancelled remotely. As per O. Reg. 79/10, s. 9 (1) 1. iii, such doors are to be equipped with an audible alarm that allows calls to be canceled only at the point of activation. The point of activation is the door.

2. As a result of the home's Resident Quality Inspection, conducted in June 2014, it was identified, by Inspector #148, that the main entrance/exit doors, in both buildings, were not equipped with an alarm. As a result of this, a lack of alarms at stairway doors, and non-compliance related to doors that lead to non-residential areas, Compliance Order # 002 was served to the licensee on June 25th, 2014. The compliance date for CO #002 was December 22, 2014.

On January 14th, 2015, Inspector #133 began a follow up inspection to verify that the doors in question had been alarmed as prescribed by the legislation. Following discussion with the home's Facility Manager (FM) and Administrator on January 14th, 2015, it was revealed that neither door had been alarmed. No corrective actions had been taken in relation to these doors. The home's Administrator indicated that it had not been understood that these doors required alarms.

3. This widespread non compliance related to door alarms presents a potential risk to the residents of the home.
(133)

2. The licensee failed to comply with O. Reg 79/10, s.9 (1) 1. (i) in that the licensee has failed to ensure that all resident accessible doors leading to stairways, and all resident accessible doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, are kept closed and locked.

This is specifically related to the main exit/entrance door for the building known as the Houses.

The main entrance/exit of the building known as the Houses consists of two sets of sliding doors that lead to the outside of the home. When exiting the building a person would first exit through the inner sliding door by using an access key card that activates the automatic opening function. Alternately, staff at the reception desk can cause the door to open remotely. Once past the inner door and within the vestibule, the outer sliding door will open automatically by motion detection. Neither one of these doors is alarmed as prescribed by O. Reg. 79/10, s. 9 (1) 1. iii. This non-compliance has been addressed within this inspection report. The licensee is required to ensure that one of these doors is alarmed as prescribed. In addition to a lack of an alarm, on January 15th, 2014, Inspector #133 observed that neither door was locked. The inner door is equipped with a thumb lock only and there is no lock of any kind on the outer exit door. During discussion, at the entrance area, the Administrator explained to the Inspector that the thumb lock is engaged to lock the inner door at approximately 11pm each night. The inner door is unlocked at 8am, when the Program Admin Clerk (PAC, staff # S103) arrives for the day. The Inspector demonstrated to the Administrator how they could slide the door open.It was agreed that the door was not locked and confirmed that there is no other locking mechanism on the door. Once through the inner exit door, in the vestibule, the outer exit door opens automatically. If the inner door is slid open, even slightly, it does not close automatically and there is no alarm to notify staff that the door is not fully closed.

Later that day, the Inspector spoke with the PAC and asked if they ever see people trying to slide the door open. The PAC indicated that every so often, such as every two months, they notice someone, such as a visitor or a person who

has come in for an interview, trying to slide it open. She explained that she stops them before the slide it all the way open, as it is her understanding that manually sliding it open could damage the door, and then informs them of the proper way to exit.

It is noted that the reception desk does not face the door, and as such does not offer visual access to the immediate area in front of the inner exit door. There is a video camera, within the reception area, that allows the PAC a view of the area immediately outside of the outer exit door. This allows them to verify who may be calling to come into the home.

This non-compliance is widespread as it presents a potential risk to the majority of residents within the Houses building.

(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 6th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

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