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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 5, 2018	2018_619550_0013	015167-18	Resident Quality Inspection

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Residence Saint-Louis
879 Chemin Parc Hiawatha OTTAWA ON K1C 2Z6

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

JOANNE HENRIE (550), LINDA HARKINS (126), LYNE DUCHESNE (117), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 19, 20, 23, 24, 25, 26, 27, 30, 31 and August 1, 2018.

The following intake was completed during this Critical Incident System Inspection: Log #003974-18 related to improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator/Executive Director, the Director of Care (DOC), the Associate Director of Care (ADOC), the Nurse Practitioner (NP), several Registered Nurses (RN), several Registered Practical Nurse (RPN), the Registered Dietician (RD), the Administrative Coordinator, a Physiotherapist (PT), a Physiotherapist Assistant (PTA), an Occupational Therapist (OT), several Personal Support Workers (PSW), several Housekeeping Aides (HK), a member of the Resident Council, several residents and several family members.

In addition, the inspectors reviewed resident health care records, policies related to falls, infection control and nutrition and residents' council minutes. Inspectors observed resident care and services, staff and resident interactions, and meal services.

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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **6 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.O. 2007, c.8 s. 6. (7)	CO #001	2018_548592_0006	550

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. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that ensure that drugs are administered to resident #031

in accordance with the directions for use specified by the prescriber.

This inspection is related to Log # 028501-17.

A Critical Incident System report was received by the Director on a specified date, related to a medication incident involving resident # 031. The CIS report noted that the resident was administered a medication on three specified consecutive dates when the medication was not supposed to have been administered.

A review of the resident's health care record, CIS report and home's Serious Incident document described the following incident:
Resident # 031 was scheduled to have a special procedure on a specified date. A physician's order was received indicating to not administer a specified medication two days prior to the scheduled procedure date. The physician's order was accompanied by a consultation form identifying that the specified medication was not to be given three days prior to the procedure date. There was an additional notation on the form from a specialist requesting that the last dose of the specified medication be administered on a specified date which was four days prior to the procedure date.

The NP #111 wrote the physician's order on the home's Physician Digiorder form, to be sent and processed by the pharmacy. The written order indicated to hold a specified medication on a specified date for a procedure. The NP also wrote the same order and actions taken regarding other medication, in the resident's progress notes. This order was co-signed by the resident's attending physician and processed by the pharmacy. Resident #031 was not administered the specified medication on the third day prior to the procedure date as per the medical order. The resident was administered the specified medication on the second day and the day prior to the procedure date. The day of the scheduled procedure, the resident was administered the specified medication.

The medication error was identified by RN # 122, when the home was informed that the resident was reported to have had complications during the procedure. RN #122 informed NP #111 that the specified medication which was supposed to not have been administered was administered to the resident two days prior to the procedure and the day of the procedure.

As such, resident #031 was administered drugs that were not in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. This inspection is related to Log # 026153-17.

A Critical Incident System report was received by the Director on a specified date related to a medication incident involving resident # 001. The CIS report noted that the resident was administered co-resident #032's medication.

A review of the resident #030 and #032's health care records, CIS report and home's Serious Incident document following incident:
On a specified date, resident #030 expressed having some pain. This was brought to the attention of RPN #124 who was doing the unit medication administration pass. RPN #124 had prepared the oral medications for resident #032. Resident #032 has 13 oral medication which included medication for two specific medical conditions. The RPN then prepared a medication as per resident #030 eMAR. These were added to the oral medications of resident #032 and the RPN administered resident #032's oral medications including resident #30's medication to resident #030. RPN #124 identified the medication error immediately when they returned to the medication cart to document the medication administration. RPN #124 immediately notified RN # 122 of the medication error who then assessed the resident. RN # 122 also notified resident #030's attending physician and the resident's substitute decision maker (SDM) of the medication error. Resident #030 was transferred to hospital for assessment post medication administration. The resident later returned to the home with no noted adverse effects.

Discussion held with RPN#124 who said to the inspector that the medication error did occur and that they had administered resident #032's medication to resident #030. The home's ADOC said that RPN #124 immediately reported the medication error to appropriate staff. Follow up actions were taken to ensure resident #030 receives immediate medical assessment. Resident #030 did not have any adverse effects related to this medication error as per post incident medical assessments. [s. 131. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to residents.

A review of the documentation in resident #009's health care records and interviews with several staff members indicated that resident #009 was known to be at high risk for falls and had fallen ten times in a specified period of time.

Inspector #550 reviewed the documentation in this resident's plan of care and noted documented under transferring, that the resident required assistance of one staff. Under risk for falls, it was documented to review lift and transfer techniques and ensure the appropriate pictogram was posted at head of the bed.

During an observation of resident #009's room, inspector #550 noted that there was a pictogram on the wall related to transfer. The pictogram indicated one person pivot transfer with belt and it displayed an image of one person assisting another person using a belt. It was signed by Physiotherapist #130.

During an interview, Administrator #132, DOC #119 and ADOC #104 indicated to the inspector that this resident was a one staff pivot transfer and they currently did not have a pictogram for one staff pivot transfer; they only had a pictogram for one staff pivot transfer with belt. They later modified this pictogram by striking out the part indicating "transfer with belt".

As evidenced, the plan of care did not set out clear directions to staff and others who provided direct care to resident #009 related to their transfer requirements. [s. 6. (1) (c)]

2. A review of resident #005's health care records and interviews with registered nursing staff indicated that resident #005 had sustained a fall on a specified date. The resident was found on the floor beside their bed. A Falls Risk Assessment - FRAT was conducted on a specified date approximately two months earlier by RN #133 and indicated that resident #005 was identified at medium risk for falls. Inspector #550 reviewed the resident's written plan of care, revised by RN #133 on the date the fall risk assessment was conducted and noted it was documented that this resident was at high risk for falls.

During an interview, DOC #119 and ADOC #104 indicated the plan of care for resident #005 did not provide clear directions regarding the resident's risk for falls. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the following was documented: 1. The provision of the care set out in the plan of care.

During the course of the resident quality inspection, resident #014's SDM, said to inspector #117 that they were concerns that the resident had not been receiving a bath on a specified day of the week as per the resident's and SDM's request.

The resident's current plan of care indicated that the resident was to receive a bath on two specified days per week.
On a specified date, resident #014 said to the inspector that they had received their two weekly baths that week but the resident could not recall if they had received other baths, as per the plan of care.

On that same day, PSW #105 and PSW #123 both confirmed that the resident was to have a scheduled bath on two specified days per week. They explained and showed to the inspector that the provision of baths are to be documented in the home's POC system. A review of the POC bath documentation for two specified months was conducted. The provision of baths was not documented for the planned baths on five specified dates within the review period.

The Assistant Director of Care (ADOC) #104 indicated that the Personal Support Workers (PSW) are to document the provision of care to residents on a daily basis in the

Point of Care (POC).

As such, the provision of care as it relates to resident #014 baths, was not consistently documented in POC. [s. 6. (9) 1.]

4. During the course of the resident quality inspection, resident # 008 indicated to inspector #126 that they would prefer to have two baths per week instead of one bath. Resident #008's health care record were reviewed and it was noted in the written plan of care that resident #008 was to receive a bath on Wednesday and Sunday mornings.

On July 17, 2018, discussion was held with PSW #125 and RN #126, both indicated that resident #008 was to receive a bath twice a week and the provision of baths were to be documented in Point Of Care (POC) system.

The Assistant Director of Care (ADOC) #104 indicated that the Personal Support Workers (PSW) are to document the provision of care to the residents in POC on a daily basis. The POC documentation was reviewed and it was noted that for the last 30 days (June 12-July 11, 2018), baths were signed as being given on June 17 and 20, 2018.

As such, the provision of care as it relates to resident #008 baths, was not consistently documented in POC. [s. 6. (9) 1.]

5. This inspection is related to log # 029640-17 & #003678-18.

During the course of this inspection, resident #044 indicated to inspector #126 that during a transfer from the wheelchair (w/c) to the bed they had suffered a small skin tear on the left elbow. Resident #044 indicated that there were two Personal Support Worker (PSW) in the room for the transfer with the lift and that it was an accident because of the fragile skin on their arms.

Resident #044's health care records were reviewed by inspector #126 and it was noted in the written plan of care to verify the resident's skin on every shift and to notify the nurse immediately of any new areas of skin breakdown.

Discussion held with PSW #136 who said to the inspector that one morning of the previous week, a small scab was observed on resident #044's left elbow and there was the presence of dry blood. PSW #136 indicated that Registered Practical Nurse (RPN) #103 was notified. Resident #044's health care records were reviewed and no

documentation was found in the progress notes or in POC related to the impaired skin integrity of resident #044.

The ADOC #104 documented that they had interviewed PSW #137 & #138 and both had indicated that they had done the transfer of resident #044 on a specific evening the previous week. They both indicated that before transferring the resident from the w/c to the bed, they observed blood in the area of left elbow. During the transfer, the resident's left elbow rubbed on the left arm rest and caused more bleeding. PSW #138 notified the RPN that was working that evening but did not recall who it was. Resident #044's health care records were reviewed and no documentation was found in the progress notes or in POC related to the impaired skin integrity of resident #044. Both PSWs informed ADOC # 104 that they did not know how to document those observations in POC.

The Director of Care (DOC) #119 and the Assistant Director of Care (ADOC) #104 indicated that the registered nursing staff are to document their assessment in the progress notes and the PSWs are to document the provision of care to residents in the Point of Care (POC) system on a daily basis.

As such, the provision of care as it relates to resident #044's impaired skin integrity was not documented in the progress notes and in POC. [s. 6. (9) 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 plan of care set out clear directions to staff and others who provide direct care to the residents and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any policy instituted or otherwise put in place is: (b) complied with.

According to O. Reg. 79/10, 2007, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A review of the documentation in resident #009's health care records and interviews with several staff members indicated that resident #009 was known to be at high risk for falls and fell frequently. According to the documentation in the progress notes, resident #009 fell nine times in a specified period of time and all falls except for one, were related to a specified resident behaviour. The resident did not sustain any injuries following the falls.

Inspector #550 reviewed the licensee's Fall Prevention, Long term care, policy #CLIN CAE 33LTC, revised 2018-06 TR and noted the following documented:

3.0 POST-FALL MANAGEMENT
3.3 No evidence of potential head injury or anticoagulant use - RPN assessment and interventions:
3.3.1 Notifies the RN of the resident fall, conducts the post-fall huddle, and completes the Post-Fall Huddle in PCC.
3.3.2 Completes and documents a Glasgow Coma Scale Assessment in PCC immediately then every 4 hours for 8 hours, then every shift for the next 72 hours,

informing the RN of any change in the resident's condition.

The inspector noted there was no post-fall huddle documented in PCC after the resident's fall on a specified date. There was no Glasgow Coma Scale assessment completed post-fall as per the established schedule on nine specified dates. [s. 8. (1) (a),s. 8. (1) (b)]

2. Documentation in resident #005's health care records and interview with a registered nursing staff indicated that on a specified date, resident #005 had a fall with no injuries. It was documented in the progress notes and in the RIMS report that the resident fell out of bed and was found by staff on the floor mat beside the bed.

The inspector noted there was no post-fall huddle documented in PCC after this resident's fall and a Glasgow Coma Scale Assessment was not completed as per the established schedule. [s. 8. (1) (a),s. 8. (1) (b)]

3. A review of the documentation in resident #041's health care records and interviews with several staff members indicated that resident #041 was known to be at high risk for falls.

According to the documentation in the progress notes, resident #041 fell on two specified dates. The resident did not sustain any apparent injuries following the falls.

Inspector #126 noted that there was no post-fall huddle documented in PCC after the resident's fall on the first date and there was no Glasgow Coma Scale Assessment (GCSA) completed.

The GCSA was not completed every shift for 72 hours for the fall on the second date.

As evidenced, the licensee's Fall Prevention, Long term care, policy #CLIN CAE 33LTC, revised 2018-06 TR was not complied with when a post-fall huddle was not documented in PCC after resident #005, #009 and #041 fell and there was no documentation Glasgow Coma Scale assessment according to the established schedule. [s. 8. (1) (a),s. 8. (1) (b)]

4. The licensee failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or protocol, the licensee is required to ensure that the system (b) is complied with.

As per O.Reg. s. 114. (1) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

This inspection is related to Log # 028501-17.

The home has a policy MEDICATION 06-02 LTC " Medication Transcription, Order Verification, Receipt of Medications, Long-Term Care" , in effect since January 2018, that identifies the following:
"2.1.4 – All orders must be clear and legible. Unclear or illegible orders will not be processed, and must be clarified with the prescriber by a nurse as soon as possible. Clarifications of unclear or illegible orders must be re-written as a new order."

A Critical Incident System report was received by the Director on a specified date, related to a medication incident involving resident # 031. The CIS report noted that resident was administered a medication on three specified consecutive dates when the medication was not supposed to have been administered.

A review of the resident's health care record, CIS report and home's Serious Incident document the following incident:
Resident # 031 was scheduled to have a special procedure on a specified date. A physician order was received indicating to not administer a specified medication two days prior to the scheduled procedure date. The physician order was accompanied by a consultation form identifying that the specified medication was not to be given three days prior to the procedure date. There was an additional notation on the form from a specialist requesting that the last dose of the specified medication be administered on a specified date which was four days prior to the procedure date.

The NP #111 wrote the physician order on the home's Physician Digiorder form, to be sent and processed by the pharmacy. The written order indicated to hold a specified medication on a specified date for a procedure. The NP also wrote the same order and actions taken regarding other medication, in the resident's progress notes. This order was co-signed by the resident's attending physician and processed by the pharmacy. Resident #031 was not administered the specified medication on the third day prior to the procedure date as per the medical order. The resident was administered the specified medication on the second day and the day prior to the procedure date. The day of the

scheduled procedure, the resident was administered the specified medication.

The medication error was identified by RN # 122, when the home was informed that the resident was reported to have had complications during the procedure. RN #122 informed NP #111 that the specified medication which was supposed to not have been administered was administered to the resident two days prior to the procedure and the day of the procedure.

RN #122 and NP #111 said to the inspector that medical scripts as well as consultation forms are received by the LTC home usually the same day as outpatient consultations are done. These are reviewed either by the NP or unit RN and then transcribed on the Physician Digiorder form for the pharmacy to process. Both RN #122 and NP #111 said that any unclear or illegible orders are to be clarified with the prescribing physician before being sent to pharmacy for processing and before being added to the resident's eMAR. In regards to the above incident, NP #111 said that they did not clarify the medical order when there was a discrepancy identify between the medical script and the procedure form.

The home's DOC confirmed that it is the home's policy to ensure that if there are any unclear or illegible orders, the registered nursing staff are to clarify the order. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Fall Prevention, Long term care, policy #CLIN CAE 33LTC, and the MEDICATION 06-02 LTC, Medication Transcription, Order Verification, Receipt of Medications, Long-Term Care policy are complied with, to be implemented voluntarily.

WN #4: 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:
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 has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors are kept closed and locked when they are not being supervised by staff.

On July 4 and 9, 2018, inspector #592 observed that the door to room 430-1, a nursing supply storage area located on the fourth floor on unit A was left open. This storage room was located beside resident room #432. The door was equipped with a key pad and contained nursing and medical equipment. The inspector noted that this room was accessible to the unsupervised residents walking in the area.

During an interview with RPN #100, they indicated that the door was equipped with a key pad in order to keep the door closed and locked at all times as it was a non-residential area. On both occasion, the RPN closed and locked the door once made aware by the Inspector.

On July 09, 2018, during an interview in the presence of the Administrator #132, DOC #119 and ADOC #104 all indicated that the storage room #430-1 should be closed and locked as this was a non-residential area and contained nursing and medical equipment which could be a potential risk for residents. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity if the oral tissue that includes,
(a) Mouth care in the morning and evening, including the cleaning of dentures.

This inspection is related to log #011338-18.

An incident was reported to the Director followed by the submission of a critical incident report. It was reported that on a specific date the Nurse Practitioner #111 was asked to assess resident #046's mouth condition by RPN #103. Upon assessment, the NP #111 documented that the resident was lying in bed crying. The resident's lips were dry with dried exudate, poor dental and mouth hygiene, dry food was visible to teeth and gums, palate and inside of cheek. The tongue was dry, had a map-like appearance and was erythemous.

It was documented in resident #046's written plan of care under oral hygiene, dental care that the resident required assistance related to cognitive impairment, staff were to provide appropriate oral hygiene twice daily and that the resident had their own teeth.

A progress note documented by NP #111 on the day of the assessment described the condition of the resident's mouth as per the documentation above. NP #111 provided gentle mouth care resident #046 was crying during the care.

During an interview, DOC #119 and ADOC #104 indicated to inspector #550 their internal investigation revealed that due to the condition of the resident's mouth when assessed by NP #111, the staff had not provided mouth care to resident #046. They further added that the registered nursing staff were expected to assess the condition of the residents' mouth during the administration of medications and ensure that the basic care was given to the residents by the PSWs.

As evidenced, resident #046 was not provided with the required mouth care to maintain the integrity of the oral tissue. [s. 34. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the residents receive oral care to maintain the integrity if the oral tissue that includes, (a) Mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #6: 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 has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

This inspection is related to log #024618-17.

A critical incident report was submitted to the Director reporting that resident #045 informed the ADOC via the submission of a handwritten letter that during their bath on a specified date, PSW #136 and #114 did not use proper transferring techniques when they transferred the resident to and from the chair to the bath and from the bed to the chair which caused pain to the resident. The resident told staff on several occasions that the sling was not properly applied and was causing the resident pain but the staff denied this and told the resident the sling was properly applied. As they were transferring the resident from the bed to the chair, the sling straps became unattached causing the sling to fall to the floor and the resident to fall in the wheelchair. The resident did not sustain any physical injuries.

During an interview, ADOC # 104 told inspector #550 that they had investigated a similar incident the previous year where PSW #141 and #125 had used a different size of sling to transfer this resident. The resident had complained of pain during this transfer and reported the incident to the ADOC.

An assessment by the Physiotherapist on a specified date indicated that the resident required the assistance of two staff and ceiling lift for transfer using yellow sling handles.

The resident's health care records and the home's internal investigation report was reviewed by inspector #550 including documented interviews with PSW #136 and #114. It was determined that the PSWs had not applied the sling as per the resident's care requirement; ensuring the sling was positioned for a specified medical condition. An assessment of the resident's transfer by the nursing educator #140 revealed that the resident required a different size of sling because of a change in their body weight. The ADOC #104 further indicated that the PSWs should have stopped the transfer when the resident complained of pain and request the assistance of the registered nursing staff.

As evidenced, staff did not use safe transferring and positioning devices or techniques when assisting resident #045. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The licensee has failed to ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident as already been screened sometime in the 90 days prior to admission and the documented results of this screening are available to the licensee.

During the course of this resident quality inspection, it was noted that resident # 011 was admitted on a specified date in 2017. Resident #010's health care records were reviewed by inspector #126 and it was noted that a chest x-ray for tuberculosis screening was done as per Health Assessment –Local Health Integration Network Form; seventy nine days after being admitted to the home.

Resident #008 was admitted on a specified date in 2018. Inspector #126 was not able to find any documentation indicating this resident was screened for tuberculosis within 14 days of admission.

Discussion held with Director of Care (DOC) #119, who indicated that the licensee is in the process of reviewing the Tuberculosis Monitoring Policy. DOC #119 indicated that the expectation for newly admitted residents is to have Mantoux testing or a chest x-ray done upon admission if a chest x-ray (done within a year prior to the admission date) was not available.

As evidenced, resident #008 and #010 were not screened for tuberculosis within 14 days of their admission. [s. 229. (10) 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 each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident as already been screened sometime in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

This inspection is related to log # 028501-17.

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A Critical Incident System report was received by the Director on a specified date in 2017, related to a medication incident involving resident # 031 that was identified four days earlier. The CIS report noted that the resident was administered a medication on three specified dates when the medication was supposed to have been placed "on hold".

Resident # 031 was scheduled to have a procedure on a specified date. A consultation was done in hospital where a physician wrote an order to "Hold" a specified medication for a specified time prior to the procedure. The medical script was accompanied by a hospital form from the consultation clinic identifying that a specified medication was not to be given on three specified dates. There was an additional notation on the form indicating that, another physician corrected the order, requesting that the last dose of the specified medication be on a specified date; four days prior to the surgery.

Nurse Practitioner NP #111 dated and initialed the medical script and the consultation form fourteen days prior to the date of the scheduled procedure. The NP #111 wrote the physician's medication order on the home's Physician Digiorder form, to be sent and processed by the pharmacy. The written order was as follows: "Hold a specified medication on a specified date". This order was co-signed by the resident's attending physician and processed by the pharmacy.

Three days prior to the procedure, resident #031 was not administered a specified medication as per the medical order. On days one and two prior to the procedure date, the resident was administered the specified medication. The day of the scheduled procedure, the resident was administered the specified medication. The resident was then transferred to hospital for the planned surgical procedure.

The day of the procedure, the medication error was identified by RN # 122, when the home was informed by the resident's family member that the resident was reported to have had complications during the procedure. RN #122 informed NP #111 that the specified medication was administered on the two days prior and the day of the procedure. The NP #111 contacted the hospital to advise them of the medication error. The home's DOC, Administrator and Medical Director were immediately informed of the medication error as well as the resident's family member.

The specified medication was to have been "on hold" two days prior to the scheduled procedure and the day of the procedure, in preparation for a planned procedure. The administration of the medication posed a risk of harm to the resident. As such, the home should have reported the improper treatment of the resident that posed a risk of harm to resident #031 immediately, when it was identified that the specified medication had been administered to the resident. [s. 24. (1) 1.]

WN #9: 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 has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, are labelled within 48 hours.

During the course of this inspection, the following unlabeled personal items were observed by inspectors:

In bathroom shared between room 218 and 220, two bars soap with crumbs were observed on top of the counter.

In bathroom shared by room 304 and 306, one bar of soap was observed on top of the counter and two blue bed pans were observed stored on the grab bar behind the toilet.

In bathroom shared between room 426 and 428, there was one white plastic urine collector observed.

DOC #119 indicated to inspector #126 that the resident's personal items are to be labeled with each resident's name and that this is a problem in this home. [s. 37. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are dressed appropriately, suitable to the time of day and in accordance with his/her preferences, in his/her own clean clothing and appropriate clean footwear.

Resident #14 is dependent for all aspects of personal. The resident's plan of care identifies that the person requires one staff assistance for dressing and that the resident is to be dressed appropriately for the time of day.

On July 10, 2018, inspector #117 observed that resident #14 was finishing the morning breakfast with staff assistance. The resident wore a nightgown, with a shawl on the shoulders as well as pants with socks and sandals. The resident was observed at 1030 hours, 1135 hours, and at 1205 hours to still be wearing the same nightgown covered by a shawl in the unit dining room when the lunch time meal service was started. At 1320 hours, the inspector observed the resident in their room. The PSW #106 was putting a shawl on the resident's shoulders. The resident was wearing a short sleeved top. The nightgown was observed to be on the resident's bedside table.

At 0930 hours, resident #026 was observed to be wearing a night gown over pants and had socks with shoes on. Resident #026 was observed at 1205 hours to still be wearing the same nightgown in the unit dining room when the lunch time meal service was started. At 1320 hours, the inspector observed the resident in their room. The resident had been changed and was now wearing a top over the pants. Resident #026's plan of care identified that the resident was dependent for all care and required one person assistance with dressing and care and the resident was to be appropriately dressed for the time of day.

At 1145 hours resident #012 was observed to be in their room, seated in a wheelchair, wearing a nightgown over dark pants. The resident had shoes and sock on. At 1205

hours the resident was observed being brought to the unit dining room for the lunch time meal service, wearing the same clothing. At 1305 hours, the resident was observed to be resting in bed, still wearing the same nightgown. The home's nurse practitioner arrived in the resident's room to conduct a resident assessment. The nurse practitioner indicated to the inspector being surprised that the resident was in their nightclothes in the afternoon. Resident #012's plan of care identified that the resident was dependent for all care and required one person assistance with dressing and care and the resident was to be appropriately dressed for the time of day.

The inspector spoke with PSW #106 regarding resident #014 and #026's care and delay in getting the resident in day clothes. PSW #106 said that there had been changes in the unit's daily routine for the breakfast meal service. PSW# 106 as well as PSW # 102, # 107 and RPN # 103 said to the inspector that several weeks ago there were changes to the unit's daily routine for the breakfast meal service so that the service start at 0830 hours. To ensure that all residents have their breakfast in a timely manner, residents are now allowed to be in covered nightclothes for breakfast. Resident dressing in day clothes is done, for a majority of residents on the unit, after the breakfast meal service. PSW #102, #107 as well as RPN # 103 said that because of these changes, some residents may not be dressed in day clothes for the lunch time meal service and will be dressed in the early afternoon, such as occurred this day for residents #012, #014 and #026.

Discussion was held with the home's Administrator and DOC regarding provision of resident care and changes to the breakfast meal service. Both the Administrator and the DOC said that the changes to the breakfast meal service was to ensure that residents have their breakfast served in a timely manner. Staff are then to ensure that residents receive their morning care and that the residents be dressed in an appropriate manner for the respective time of day. As such, resident should be dressed in their day clothes for the lunch time meal service, unless specified otherwise in the resident's plan of care. [s. 40.]

Issued on this 24th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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) :	JOANNE HENRIE (550), LINDA HARKINS (126), LYNE DUCHESNE (117), MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2018_619550_0013
Log No. / No de registre :	015167-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 5, 2018
Licensee / Titulaire de permis :	Bruyère Continuing Care Inc. 43 Bruyère Street, OTTAWA, ON, K1N-5C8
LTC Home / Foyer de SLD :	Residence Saint-Louis 879 Chemin Parc Hiawatha, OTTAWA, ON, K1C-2Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Melissa Donskov

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

Order / Ordre :

The licensee must be compliant with s. 131 (2) of the O.Reg. 79/10.
Specifically the licensee shall:

1. Ensure that pre-operative prescription medication orders, are reviewed and verified by registered nursing staff before being added to the resident's medication regime and administered in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. 2. This inspection is related to Log # 026153-17.

A Critical Incident System report was received by the Director on a specified date related to a medication incident involving resident # 001. The CIS report noted that the resident was administered co-resident #032's medication.

A review of the resident #030 and #032's health care records, CIS report and home's Serious Incident document following incident:
On a specified date, resident #030 expressed having some pain. This was brought to the attention of RPN #124 who was doing the unit medication administration pass. RPN #124 had prepared the oral medications for resident #032. Resident #032 has 13 oral medication which included medication for two specific medical conditions. The RPN then prepared a medication as per resident #030 eMAR. These were added to the oral medications of resident #032 and the RPN administered resident #032's oral medications including resident #30's medication to resident #030. RPN #124 identified the medication error immediately when they returned to the medication cart to document the medication administration. RPN #124 immediately notified RN # 122 of the

medication error who then assessed the resident. RN # 122 also notified resident #030's attending physician and the resident's substitute decision maker (SDM) of the medication error. Resident #030 was transferred to hospital for assessment post medication administration. The resident later returned to the home with no noted adverse effects.

Discussion held with RPN#124 who said to the inspector that the medication error did occur and that they had administered resident #032's medication to resident #030. The home's ADOC said that RPN #124 immediately reported the medication error to appropriate staff. Follow up actions were taken to ensure resident #030 receives immediate medical assessment. Resident #030 did not have any adverse effects related to this medication error as per post incident medical assessments. (117)

2. 1. The licensee failed to ensure that ensure that drugs are administered to resident #031 in accordance with the directions for use specified by the prescriber.

This inspection is related to Log # 028501-17.

A Critical Incident System report was received by the Director on a specified date, related to a medication incident involving resident # 031. The CIS report noted that the resident was administered a medication on three specified consecutive dates when the medication was not supposed to have been administered.

A review of the resident's health care record, CIS report and home's Serious Incident document described the following incident:
Resident # 031 was scheduled to have a special procedure on a specified date. A physician's order was received indicating to not administer a specified medication two days prior to the scheduled procedure date. The physician's order was accompanied by a consultation form identifying that the specified medication was not to be given three days prior to the procedure date. There was an additional notation on the form from a specialist requesting that the last dose of the specified medication be administered on a specified date which was four days prior to the procedure date.

The NP #111 wrote the physician's order on the home's Physician Digiorder form, to be sent and processed by the pharmacy. The written order indicated to

hold a specified medication on a specified date for a procedure. The NP also wrote the same order and actions taken regarding other medication, in the resident's progress notes. This order was co-signed by the resident's attending physician and processed by the pharmacy.
Resident #031 was not administered the specified medication on the third day prior to the procedure date as per the medical order. The resident was administered the specified medication on the second day and the day prior to the procedure date. The day of the scheduled procedure, the resident was administered the specified medication.

The medication error was identified by RN # 122, when the home was informed that the resident was reported to have had complications during the procedure. RN #122 informed NP #111 that the specified medication which was supposed to not have been administered was administered to the resident two days prior to the procedure and the day of the procedure.

As such, resident #031 was administered drugs that were not in accordance with the directions for use specified by the prescriber. (117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 09, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Joanne Henrie

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