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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Mar 13, 2015	2015_188168_0007	H-002065-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

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

LISA VINK (168), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 4, 5, 6, 9, 10, 11 and 12, 2015.

Critical Incident Inspection H-001763-14 was completed concurrently with this RQI and findings are included in this Inspection Report.

Follow Up Inspections H-00791-14, H-00792-14, H-00793-14, H-00794-14, H-00795-14, H-00796-14 and H-00876-13 were completed concurrently with this RQI and findings are included in this Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Food Services Manager, Programs Manager, Restorative Care Manager, registered nursing staff, personal support workers (PWS's), dietary staff, housekeeping staff, families and residents.

During the course of the inspection the inspectors: toured the home, observed the provision of care and services and reviewed relevant documents including but not limited to: clinical health records, meeting minutes, policies/procedures and menus.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **8 VPC(s)**
- **4 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. 11. (1)	CO #003	2014_322156_0004	168
O.Reg 79/10 s. 26. (4)	CO #004	2014_322156_0004	168
O.Reg 79/10 s. 33. (1)	CO #005	2014_322156_0004	168
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2014_322156_0004	528

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used that the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices to minimize the risk to the resident.

A review of the home's bed entrapment audit documentation, completed by an outside service provider on May 16, 2012, identified that six beds, including resident #40's bed, were not tested for zones of entrapment, for a variety of reasons, including lack of bed rails. During the inspection it was observed that resident #40's bed now had two quarter assist rails and PSW's confirmed that the rails were raised when the bed was in use. The DOC identified that some of the six beds had been replaced and or modified since the initial testing; however, to her knowledge, based on the entrapment audit that the identified bed for resident #40 was not tested for zones of entrapment. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Review of the home's bed entrapment audit documentation, completed on May 16, 2012, by an outside service provider, identified that 29 beds failed one or more of zones 2, 3, or 4. Discussion with the DOC identified that action was taken to manage some of the risks by the former Environmental Supervisor; however, specific actions were not known and there was no documentation available as to the action taken. It was confirmed that the home did not have the necessary equipment to test for zones of entrapment and that beds had not been retested since May 2012. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all menu items were prepared according to the planned menu.

A. On March 11, 2015, spinach salad was posted on the daily menu for lunch. During meal service, the salad served, for all textures, did not contain spinach, which was confirmed by the cook. The FSM confirmed that the spinach salad was on the planned menu and should have been prepared.

B. On March 9, 2015, the planned menu for the afternoon snack pass, was crispy rice square, sugar cookies and puree vanilla wafers. The PSW serving the snacks reported there were three packages of pre-packaged rice crispy squares, arrowroot cookies, crackers, pudding, apple sauce, and a bowl of puree cake available. Multiple residents were not offered planned snack menu items as they were not available on the snack cart. Interview with the FSM confirmed the planned menu items should have been offered and available for residents at the pass. [s. 72. (2) (d)]

2. The licensee failed to ensure that all foods in the food production system were served using methods to preserve taste, nutritive value, appearance and food quality.

A. On March 4 and 9, 2015, during the lunch meal, puree bread served to residents appeared runny and was pooling on the plate. The cook reported that the home's practice was to prepare puree bread to a honey consistency; however, confirmed that the bread appeared runny on March 9, 2015. Interview with the FSM confirmed that the bread was runny. The bread recipe was reviewed and noted that staff were to prepare it to the "desired consistency".

B. On March 11, 2015, during the lunch meal, puree foods served to residents appeared runny, did not hold their shape and pooled on the plate. These foods included puree perogies, peameal bacon, bean salad, bread, sandwich meat and garden salad. A PSW reported that a puree meal served to a resident appeared runny. The RD confirmed puree food should not pool, instead hold its shape to maintain nutrient density, palatability, appeal and ease of eating. [s. 72. (3) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set out the planned care for the resident.

Resident #13 was noted to experience constipated bowel movements and was identified to be at high risk for constipation during a nutritional care assessment in January 2015, due to a number of factors. The resident was not meeting identified hydration targets, frequently refused a stool softening medication and experienced inactivity. A Resident

Assessment Protocol (RAP) dated March 6, 2015, confirmed that the resident had experienced constipation in the past quarter and that a referral had been placed to the RD for assessment. A review of the plan of care in place on March 12, 2015, did not include a focus statement regarding the planned care for the resident related to constipation, which was confirmed with registered staff. [s. 6. (1) (a)]

2. The licensee failed to ensure that care set out in the plan of care was provided to the resident, as specified in the plan.

A. The plan of care for resident #50 indicated they were at high nutritional risk and to offer cream of wheat cereal when their meal was refused. During noon meal on March 10, 2015, the resident had consumed less than 25 percent of their meal. The PSW assisting the resident confirmed the plan of care stated they were to be offered cream of wheat when they refused a meal and that this did not occur. The RD confirmed the resident was to be offered cream of wheat when they refused to eat. (585)

B. On March 10, 2015, resident #13 was observed seated in a wheelchair in the upright position with their head flexed forward. The plan of care identified that the resident used a tilt wheelchair daily and required the assistance of two staff for repositioning every two hours. From 1320 until 1650 hours, the resident was observed by the inspector for the provision of care. The resident was not repositioned by staff during the time of the observation. At 1430 hours, a PSW assisted the resident with afternoon snack, but did not complete repositioning. At 1650 hours, the resident was portered to the dining room; however, staff did not complete repositioning. For 3.5 hours the resident was not repositioned, while up in their wheelchair, as outlined in their plan of care. (528) [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

The plan of care for resident #50 identified that they occasionally required extensive assistance with eating at meals when tired. On March 9, 10 and 11, 2015, during the noon meal and March 12, 2015, during the breakfast meal, the resident received extensive assistance with eating. On March 10, 2015, the resident was observed at a meal when they did not receive assistance from staff at which time they ate less than 25 percent. Regular PSW's reported the resident was often tired and received total assistance with eating to help improve their total meal intake. One PSW reported the resident required this level of assistance daily at breakfast and lunch for approximately

the past month. One regular registered nursing staff reported the resident required extensive assistance at some point when eating breakfast or lunch daily. The resident's plan of care was not reassessed when their care needs changed related to the ongoing need for additional assistance at meal times. [s. 6. (10) (b)]

4. The licensee failed to ensure that when the resident was reassessed and the plan of care was reviewed and revised because the care had not been effective, that different approaches were considered in the revision of the plan of care.

A. The plan of care, reviewed on March 9, 2015, for resident #50 identified they were at high nutritional risk and were to receive half a puree banana during the afternoon snack pass for nutritional adequacy. During afternoon snack pass on March 9, 2015, the resident did not receive a banana, nor did the cart snack list include this intervention. The plan of care was reviewed again on March 10, 2015 and no longer included the need for the banana. The FSM reported their dietary tracking audits indicated the banana was not being consumed and as a result, they removed this intervention from the plan of care. The FSM confirmed they did not consider other approaches in the revision of the plan of care when they discontinued the banana. (585)

B. Resident #13 had a plan of care to receive pudding during the afternoon snack pass for nutrition adequacy, to maintain skin integrity and hydration. During the afternoon snack pass, on March 9, 2015, the snack cart diet list did not include pudding for the resident, nor was pudding provided. The FSM reported their dietary tracking audits indicated the pudding was not being consumed and as a result, they removed this intervention from the plan of care. The FSM confirmed they did not consider other approaches in the revision of the plan of care. The RD indicated that the pudding was an intervention that still needed to be in place. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 included the planned care for the resident, that when the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, and that when the resident is reassessed and plan of care reviewed and revised because the care set out in the plan is not effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a snack in the afternoon.

During the afternoon snack pass on March 9, 2015, residents #13 and #52 were not offered a snack.
i. The PSW who served the snacks was interviewed and stated that resident #13, who was at moderate nutritional risk and not meeting their target fluid requirement, previously had a labeled pudding snack; however, that the cart diet list no longer included this intervention and therefore no snack was served.
ii. The PSW who served the snacks confirmed during an interview that a snack was not provided to resident #52. The RD confirmed that the resident was at high nutritional risk and although did not have a prescribed snack should have been offered a snack item as per the menu.

The FSM confirmed that all residents should be offered, at a minimum, a snack in the afternoon. [s. 71. (3) (c)]

2. The licensee failed to ensure that planned menu items were offered at snack time.

A. On March 9, 2015, during the afternoon nourishment pass multiple residents were not offered a choice of beverage.
i. Resident #53 was served a yogurt and coffee and reported that they were not offered a choice of drink or snack, which was confirmed by the PSW.
ii. Resident #54 was served nectar juice and apple sauce; however, no other choices were offered, which was confirmed by the PSW.

B) On March 10, 2015, during the morning beverage pass resident #55 was offered grape juice; however, was not offered a choice of the other beverage available, which was confirmed by the PSW. [s. 71. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 planned menu items are offered at snack time, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A. The home's policy for Management of Concerns/Complaints/Compliments, LP-B-20, last revised October 2014, directed staff to use the HEART approach in response to a concern or complaint in an effort to resolve the issue. If concerns could not be resolved immediately, staff were to initiate a Client Service Response (CSR) form and forward it to the ED and the member of the team responsible for managing the concern.

In June 2014, family reported missing dentures on behalf of resident #16. Registered staff documented that an initial search was conducted; however, the dentures were not located, which was communicated to the Substitute Decision Maker. The Concern/Complaints log was reviewed for 2014 and 2015, and did not include a CSR form for the missing dentures. Interview with the ED confirmed that missing personal

items that were not located would be considered an unresolved concern and a CSR form would be completed. Interview with the ED indicated that she was not aware of the missing dentures, as a CSR form was not completed, as required in the policy. (528)

B. The home's procedure Pain Assessment and Symptom Management, LTC-E-80, last revised August 2012, indicated that:
"1. On admission, the nurse will screen the resident for past history of pain and the management of that pain.
2. If pain is identified on admission, or the resident has a diagnosis which could result in pain and/or is receiving regular pain medication, a pain monitoring tool will be initiated for a minimum of 72 hours.
4. The nurse will review the MDS assessment related to pain (sections J2 and J3), and an interdisciplinary review of the resident's outcomes, RAPs or CAPs will be completed to determine the need for: additional pain assessment and monitoring; additional referral."

Resident #12 was admitted to the home with Arthritis, a diagnosis which could result in pain. The resident reported pain the day after admission. A pain assessment completed four days after admission gave a description of pain as communicated by the resident. A review of the clinical record did not include the initiation of a pain flow sheet until nine days after admission and did not include an admission Resident Assessment Protocol (RAP) related to pain as the Minimum Data Set (MDS) assessment was coded as no pain was present. Interview with the ADOC confirmed the expectation that a pain monitoring tool be initiated on admission and that a RAP be completed due to the presence of pain during the observation period. It was confirmed that the home's procedure was not complied with. (168)

C. The home's procedure Continence Care, LTC-E-50, last revised May 2013, indicated that "The nurse will: initiate the 3 day continence assessment on admission and/or if there is a change in level of continence".

Resident #12 had a change in bowel continence as identified in MDS assessments. The resident was identified as usually continent of bowels on admission, the next assessment noted frequent incontinence of bowels and the most recent assessment was identified as incontinent of bowels. A review of the clinical record did not include a 3 day continence assessment following the changes in continent levels, as required, as confirmed by the Restorative Care Manager. (168) [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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #6: 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).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not supervised by staff.

Resident #11 had a known behaviour of wandering. A review of the clinical record identified that on a specified date in 2015, the resident was found wandering inside the lodge at 0430 hours by a staff member who promptly returned them to the long term care home. An internal investigation was conducted, as identified by the DOC, and it was confirmed that the kitchen doors, off of the dining room, were unlocked at the time of the incident. The kitchen was considered a non-residential area. Interview conducted with a dietary aide confirmed that staff worked in the kitchen until approximately 2100 hours nightly and then would lock up the kitchen for safety until morning. [s. 9. (1) 2.]

2. The licensee failed to ensure that there was a written policy that dealt with doors leading to secure outside areas and whether they must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

During the course of the inspection, a door in the lounge, leading to a secured outdoor area, was observed to be unlocked with an alarm that sounded when the door was opened. On March 9, 2015, resident #16 was observed to open the door and shuffle outside without a coat or other winter clothing. The area outside was snow covered and not cleared for use. A review of the resident's plan of care identified that they were cognitively impaired and required a walker for safe ambulation. Within a minute of the door alarm sounding, two PSW staff responded to assist the resident back into the home.

Interview with the DOC confirmed that the home did not have a policy related to doors leading to secured areas and whether they must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. [s. 9. (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 all doors leading to non-residential areas are kept closed and locked when they are not supervised by staff and that there is a written policy that deals with doors leading to secure outside areas and whether they must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken to meet the needs of the resident with responsive behaviours included documentation of the resident's responses to interventions.

A. In November 2014, resident #60 was involved in an incident with resident #11. There were no physical injuries identified as result of this incident; however, interventions were initiated in an effort to prevent recurrence including the implementation of every 15 minute monitoring checks for both residents.
A review of the clinical record and 15 Minute Safety Checklist for both residents noted that the records were incomplete.

The records for resident #60 were reviewed for 9 days following the incident and it was identified that the records were not completed as follows:
i. Day 1 following the incident the records were incomplete from 0600 until 1400 hours.
ii. Day 2 following the incident the records were incomplete from 0615 until 1345 hours.
iii. Day 3 following the incident the records were incomplete from 2000 until 2145 hours.
iv. Day 4 following the incident the records were incomplete from 0245 until 0545 hours and again from 1415 until 2145 hours.
v. Day 5 following the incident the records were incomplete from 1100 until 1345 hours.
vi. Day 6 following the incident the records were incomplete from 0615 until 2345 hours.
vii. Day 7 following the incident the records were incomplete from 0001 until 1345 hours.
viii. Day 8 following the incident the records were incomplete from 0615 until 1345 hours and again from 2215 until 2345 hours.
ix. Day 9 following the incident the records were incomplete from 0001 until 2345 hours.

The records for resident #11 were reviewed for 3 days following the incident and it was identified that the records were not completed as follows:
i. Day 1 following the incident the records were incomplete from 0615 until 1345 hours.
ii. Day 2 following the incident the records were incomplete from 0615 until 1345 hours.
iii. Day 3 following the incident the records were incomplete from 1415 until 2145 hours.

Interview with the DOC confirmed that staff were aware of the interventions and monitoring had been completed; however, in her opinion, staff had failed to document the interventions as required. (168)

B. In December 2014, resident #16 had an altercation with a co-resident where no injuries were noted. As a result of the incident, additional interventions were put in place including but not limited to, Dementia Observation System (DOS) charting, to document the resident's behaviours every half hour. A review of the DOS charting post incident, identified that the resident's behaviours were not consistently documented every half hour. Interview with registered and PSW staff confirmed that the behaviours were not documented every 30 minutes on DOS as required. (528) [s. 53. (4) (c)]

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 actions taken to meet the needs of the resident with responsive behaviours, includes documentation of the resident's responses to interventions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the daily and weekly menu were communicated to residents.

On March 4 and 11, 2015, in the lounge dining area, residents were observed eating their meal. There was no posted menus available in the lounge or visible outside of the room. The FSM confirmed that the area served as a permanent dining area for the residents and that a menu was not posted in the area. [s. 73. (1) 1.]

2. The licensee failed to ensure that proper techniques were used to assist a resident with eating, including safe positioning.

On March 12, 2015, during the morning snack pass, resident #21 was observed receiving total assistance to consume their beverage from a PSW. The resident was noted to be tilted back past 90 degrees, with their head tilted back. The PSW who provided assistance confirmed the resident should be inclined to 90 degrees when eating or drinking. [s. 73. (1) 10.]

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 proper techniques are used to assist resident with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. On March 10, 2015, at 1620 hours, registered staff were administering medications in the lounge. The medication cart was located in the hall, outside of the lounge and was observed to be unlocked and unattended with four residents in wheelchairs present in the hall. The inspector was able to open and close cart drawers without the knowledge of the registered staff. When staff returned to the medication cart, it was confirmed that she was unaware the cart was unlocked and she locked it immediately. (528)

B. On March 10, 2015, at 1210 hours, a medication cart was observed unlocked and unattended outside of the small dining room. The inspector was able to open the drawers on the cart that contained medications without staff present. Registered staff confirmed the cart was unlocked and unattended. (585) [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy Routine Practices, IPC-B-10, last revised December 2014, directed all staff to complete hand hygiene at point of care, before and after resident contact or resident environment contact, before aseptic techniques, and after bodily fluid exposure.

A. On March 4, 2015, lunch was observed in the large dining room. During the course of the meal service, a dietary aide was observed collecting dirty dishes and then serving other residents their entree and/or dessert without performing hand hygiene. Interview with the dietary aide confirmed that hand hygiene was to be completed between cleaning dirty dishes and serving food, as outlined in the home's policy. (528)

B. On March 12, 2015, during morning snack pass, a PSW was observed feeding a resident and rubbing their nose. The PSW was not noted to perform hand hygiene during the snack pass, which was confirmed. (585) [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in the plan of care only if the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

In July 2013, a bed rail assessment for resident #13 identified they required one or two quarter bed rails when in bed to facilitate bed mobility. A review of the plan of care on March 5, 2015, did not include a consent for the use of bed rails by the substitute decision maker. Interview with restorative care staff confirmed that the rails had been in place since July 2013; however, consent was not obtained until March 5, 2015. [s. 33. (4) 4.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the course of the inspection, resident #30's room was noted to have a lingering offensive odour. A review of progress notes for the resident identified behaviours which might have contributed to the odour since November 2014. Interview with the DOC on March 10, 2015, confirmed that current interventions had not been effective in addressing the odour and additional interventions were being trialed. The home was unable to provide a formalized procedure specific to dealing with lingering and offensive odours. [s. 87. (2) (d)]

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

Issued on this 30th day of March, 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2015_188168_0007
Log No. / Registre no:	H-002065-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 13, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	TELFER PLACE 245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To REVERA LONG TERM 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. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

Where bed rails are used, the licensee shall do the following;
1. Evaluate each bed system to identify risk of entrapment and document this evaluation;
2. Take steps to prevent risk of entrapment by performing the necessary modifications according to the bed system evaluation and document the actions taken;
3. Re-evaluate bed systems, on an ongoing basis, when they have been altered or modified and document this evaluation.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used that the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices to minimize the risk to the resident.

A review of the home's bed entrapment audit documentation, completed by an outside service provider on May 16, 2012, identified that six beds, including resident #40's bed, were not tested for zones of entrapment, for a variety of reasons, including lack of bed rails. During the inspection it was observed that resident #40's bed now had two quarter assist rails and PSW's confirmed that the rails were raised when the bed was in use. The DOC identified that some of the six beds had been replaced and or modified since the initial testing; however, to her knowledge, based on the entrapment audit that the identified bed for resident #40 was not tested for zones of entrapment.

The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Review of the home's bed entrapment audit documentation, completed on May 16, 2012, by an outside service provider, identified that 29 beds failed one or more of zones 2, 3, or 4. Discussion with the DOC identified that action was taken to manage some of the risks by the former Environmental Supervisor; however, specific actions were not known and there was no documentation available as to the action taken. It was confirmed that the home did not have the necessary equipment to test for zones of entrapment and that beds had not been retested since May 2012. (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall complete the following;
1. Develop or revise current recipes for all pureed menu items to clearly direct staff on the desired consistency of each item included on the menu.
2. Establish a process for ongoing monitoring of pureed menu items to confirm that the desired consistency is achieved for preserving and maintaining nutritive value, appearance and quality of the food served to the residents.
3. A process for the reporting of concerns related to food consistency and documentation of actions taken to address the concerns.

Grounds / Motifs :

1. Identified as a VPC in June 2013.

The licensee failed to ensure that all foods in the food production system were served using methods to preserve taste, nutritive value, appearance and food quality.

A. On March 4 and 9, 2015, during the lunch meal, puree bread served to residents appeared runny and was pooling on the plate. The cook reported that the home's practice was to prepare puree bread to a honey consistency; however, confirmed that the bread appeared runny on March 9, 2015. Interview with the FSM confirmed that the bread was runny. The bread recipe was reviewed and noted that staff were to prepare it to the "desired consistency".

B. On March 11, 2015, during the lunch meal, puree foods served to residents appeared runny, did not hold their shape and pooled on the plate. These foods included puree perogies, peameal bacon, bean salad, bread, sandwich meat and garden salad. A PSW reported that a puree meal served to a resident appeared runny. The RD confirmed puree food should not pool, instead hold its shape to maintain nutrient density, palatability, appeal and ease of eating. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2014_322156_0004, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents including residents #50 and #13 are provided with nutritional care and repositioning according to their plans of care.

The plan shall include but not be limited to;
1. Education to front line staff regarding the identified care needs of residents in the areas of nutrition and positioning and where they may access this information on an ongoing basis.
2. Clear direction regarding who is responsible to provide the required care to residents as specified in their plans related to nutrition and repositioning.
3. The establishment of a monitoring process to ensure that specific interventions as identified in the plans of care are provided to residents as required.

The plan is to be submitted to lisa.vink@ontario.ca by April 7, 2015.

Grounds / Motifs :

1. Previously served as a CO in 2013 and 2014.

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

A. The plan of care for resident #50 indicated they were at high nutritional risk and to offer cream of wheat cereal when their meal was refused. During noon meal on March 10, 2015, the resident had consumed less than 25 percent of their meal. The PSW assisting the resident confirmed the plan of care stated they were to be offered cream of wheat when they refused a meal and that this did not occur. The RD confirmed the resident was to be offered cream of wheat when they refused to eat. (585)

B. On March 10, 2015, resident #13 was observed seated in a wheelchair in the upright position with their head flexed forward. The plan of care identified that the resident used a tilt wheelchair daily and required the assistance of two staff for repositioning every two hours. From 1320 until 1650 hours, the resident was observed by the inspector for the provision of care. The resident was not repositioned by staff during the time of the observation. At 1430 hours, a PSW assisted the resident with afternoon snack, but did not complete repositioning. At 1650 hours, the resident was portered to the dining room; however, staff did not complete repositioning. For 3.5 hours the resident was not repositioned, while up in their wheelchair, as outlined in their plan of care. (528) (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2014_322156_0004, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are offered snacks in the afternoon and evening.

This plan shall include but not be limited to;
1. Education for all direct care and dietary staff regarding expectations for the offering of snacks.
2. A process in place to ensure that snacks are prepared and offered to all residents and communication to the appropriate person if the snack is not consumed for any reason.

The plan shall be submitted to lisa.vink@ontario.ca by April 7, 2015.

Grounds / Motifs :

1. Previously served as a CO in 2013 and 2014.

The licensee failed to ensure that each resident was offered a snack in the afternoon.

During the afternoon snack pass on March 9, 2015, residents #13 and #52 were not offered a snack.
i. The PSW who served the snacks was interviewed and stated that resident #13, who was at moderate nutritional risk and not meeting their target fluid requirement, previously had a labeled pudding snack; however, that the cart diet list no longer included this intervention and therefore no snack was served.
ii. The PSW who served the snacks confirmed during an interview that a snack was not provided to resident #52. The RD confirmed that the resident was at high nutritional risk and although did not have a prescribed snack should have been offered a snack item as per the menu.

The FSM confirmed that all residents should be offered, at a minimum, a snack in the afternoon. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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 13th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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