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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 18, 2016	2016_389601_0005	003982-16	Complaint

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street TRENTON ON K8V 1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET TRENTON ON K8V 1H9

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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 8, 9, 10, 21, 22, 29, 2016.

Critical Incident log #005639-16 and #000617-16 related to inappropriate touching and allegations of sexual abuse.

Complaint inspection log #003982-16 related to staffing levels affecting resident care including medication administration.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), RAI Coordinator (RAI), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Pharmacist, residents and family member.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Responsive Behaviours
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that their policy related to medication administration was followed to ensure safe, effective administration of medication for resident #001, #006, #009, and #010.

Related to log #003982:

O. Reg. 79/10, 114. (2) states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure that accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Review of the licensee's Administration of Medications - General Considerations Policy number TC-1022.2 indicated that medications are administered within one hour of the scheduled time, except medications to be given with food, or before or after meal/food orders, which are administered precisely as ordered. If there is a question about the specific time a medication should be given, consult with the consultant pharmacist or pharmacy provider.

Review of the licensee's electronic medication system identified that the administering nurse signs for the residents medication on the e-MAR and e-TAR system. The e-MAR and e-TAR system records the actual time that the residents medication was signed as administered by the nurse on the Medication Treatment Administration Record.

Related to resident #001:

During an interview, resident #001 indicated that medication is not always administered according to the scheduled times.

Review of resident #001’s Medication Treatment Administration Record for an identified two months and twenty-one day period identified that resident #001’s medication scheduled to be administered included five identified medication to be administered at 0800 hour and two identified medication to be administered at 2000 hours.

It was identified that resident #001’s 0800 hour medication were administered greater than one hour following the administration scheduled time on fifty-four occasions ranging from eighteen minutes to one hour and twenty-six minutes late during the identified

period of two months and twenty-one days.

It was identified that resident #001's 2000 hour medication were administered greater than one hour following the administration scheduled time on forty-three occasions ranging from nine minutes to one hour and thirty-nine minutes late during the identified period of two months and twenty-one days.

Review of resident #001's Physician Orders and the Medication/Treatment Administration Record for an identified two months and twenty-one day period identified that resident #001 had a Physician order for an identified medication to be applied at 0800 hour and to be removed at 2000 hour.

During the identified period of two months and twenty-one days, resident #001's identified medication that was scheduled for 0800 hours was not administered within one hour of the scheduled time on fifty-four occasions and the identified medication that was scheduled to be removed at 2000 hours was not removed within one hour of the scheduled time on forty-three occasions. It was identified that the identified medication remained on resident #001 greater than twelve hours on twelve occasions during the period of two months and twenty-one days.

During an interview, Pharmacist #105 indicated that resident #001's identified medication should be applied according to the home's policy for medication administration at 0800 and to be removed at 2000 hours. According to Pharmacist #105, resident #001's identified medication should be in place for at least eight hours to ensure appropriate absorption of the medication or should not be in place greater than twelve hours due to the potential risk of increased absorption of the medication.

During the identified period of two months and twenty-one days resident #001's identified medication was not applied within one hour of the scheduled time on fifty-four occasions and was not removed within one hour of the scheduled time on forty-three occasions during the identified time period. There was a potential risk of resident #001 having an increased absorption of the identified medication due to the medication being in place for greater than twelve hours on twelve occasions.

Related to resident #006:

Review of resident #006's Medication Treatment Administration Record for an identified period of two months and twenty-one days identified that resident #006's medication

scheduled to be administered included eight identified medication at 0800 hours, one identified medication at 1200 hours, and four identified medication at 1700 hours.

It was identified that resident #006’s 0800 hour medications were administered greater than one hour following the administration scheduled time on thirty-seven occasions ranging from five minutes to three hours and sixteen minutes late during an identified two month and twenty-one day period.

It was identified that resident #006’s 1700 hour medications were administered greater than one hour following the administration scheduled time on twenty-nine occasions ranging from three minutes to fifty-four minutes late during an identified two month and twenty-one day period.

During an interview, Pharmacist #105 indicated resident #006's medications should be given according to the home's policy for medication administration and when a medication is ordered for three times a day the scheduled times are 0800, 1200, and 1700 hours. Pharmacist #105 also indicated that resident #006's identified medication should be given at the scheduled times because the identified medication peak concentration levels are usually one to three hours after administration. According to Pharmacist #105, when resident #006's 0800 hour identified medication was administered after 0900 hours it could have caused the identified medication that was administered at 1200 hours to peak at the same time temporarily increasing resident #006's blood level.

Therefore, during the period of two months and twenty-one days resident #006’s identified medication was not administered within an hour of the scheduled time on sixty-six occasions.

Related to resident #009:

Review of resident #009’s Medication Treatment Administration Record for an identified period of two months and twenty-one days identified that resident #009’s medication was scheduled to be administered included seven identified medication at 0800hour, one identified medication at 1200 hours, and two identified medication at 1700 hours.

It was identified that resident #009’s 0800 hour medications were administered greater than one hour following the administration scheduled time on twenty-nine occasions ranging from four minutes to one hour and fifty-two minutes late during the identified

period of two months and twenty-one days.

It was identified that resident #009's 1200 hour medication were administered greater than one hour following the administration scheduled time on twenty occasions ranging from five minutes to forty-seven minutes late during the identified period of two months and twenty-one days.

During an interview, Pharmacist #105 indicated that resident #009's identified medication should be given according to the home's policy for medication administration at 0800 and 1200 hours. According to Pharmacist #105, resident #009's identified medication administered after 0900 hours could potentially increase resident #009's risk for identified medical conditions due to receiving the next dose at 1200 hours.

Therefore, during the identified period of two months and twenty-one days resident #009's identified medication was not administered within an hour of the scheduled time on thirty-one occasions potentially increasing resident #009's risk for identified medical conditions.

Related to resident #010:

Review of resident #010's Medication Treatment Administration Record for an identified period of two months and twenty-one days identified that resident #010's medication scheduled to be administered included fifteen identified medication at 0800 hours, two identified medications at 1200 hours, four identified medication at 1700 hours, and two identified medication at 2000 hours.

It was identified that resident #010's 0800 hour medications were administered greater than one hour following the administration scheduled time on fifty-five occasions ranging from fourteen minutes to one hour and forty-one minutes late during an identified period of two months and twenty-one days.

It was identified that resident #010's 1200 hour medications were administered greater than one hour following the administration scheduled time on six occasions ranging from ten minutes to thirty-nine minutes late during an identified period of two months and twenty-one days.

It was identified that resident #010's 1700 hour medications were administered greater than one hour following the administration scheduled time on three occasions ranging

from nine minutes to twenty-four minutes late during an identified period of two months and twenty-one days.

It was identified that resident #010's 2000 hour medications were administered greater than one hour following the administration scheduled time on twenty-three occasions ranging from six minutes to one hour and twenty-eight minutes late during an identified period of two months and twenty-one days.

Resident #010 has an identified diagnosis that required two specific medications to manage the symptoms of the medical condition.

During an interview, Pharmacist #105 indicated that resident #010's identified medication should be given at regular intervals to manage medical condition.

Therefore, during the identified period of two months and twenty-one days resident #0010's identified medication to manage the residents medical condition included identified medication that was not administered within an hour of the scheduled time on eighty-seven occasions. Resident #010's second identified medication was not administered within an hour of the scheduled time on fifty-five occasions.

Inspector #601 observed RPN #106 administer medication for resident #006, #009, #010 and noted that RPN #106 signed on the e-MAR system for the medication provided immediately following administration.

During an interview, RPN #106 indicated that all medication administered to residents were signed on the e-MAR system immediately following medication administered. RPN #106 also indicated that the residents who go to the dining room for breakfast receive their medication prior to the residents who remain in their room for breakfast. RPN #106 also indicated that the registered staff assist with meal service and attend a morning meeting prior to completing the 0800 hour medication pass.

During an interview, the DOC indicated not being aware that the registered staffs were not administering the medication within one hour of the scheduled time as specified in the policy and that medication should be given according to the policy. [s. 8. (1) (b)]

2. Review of the licensee's Administration of Medications - General Considerations Policy number TC-1022.2 indicated medication administration is documented on the resident's medication record (MR), at the time the medication is given, by the person who

administered the medication. The resident's Medication Record is signed by the person administering a medication electronically or in the space provided under the date, and on the line for that specific medication dose. Initials on the Medication Record are verified with a full signature in the space provided.

Related to resident #001:

During an interview, resident #001 indicated that an identified topical treatment had been applied to a specified area every night when there was an identified reason and a different topical treatment was applied by the PSW during morning care on an identified date. Resident #001 also indicated the PSW's apply another identified topical treatment to an identified area morning and night.

Review of resident #001's RN's and PSW's Treatment Administration Record (TAR) during an identified eight day period identified that resident #001 Physician had prescribed two identified topical treatments to be applied as required and one identified topical treatment to be applied at bedtime.

During an interview, RPN #117 indicated that resident #001 would be capable of recalling when the topical treatment had been applied. Review of Medication Records's for resident #001 identified there was no documentation indicating that resident #001's identified topical treatment had been applied as prescribed by the Physician or as identified by resident #001.

Related to resident #006:

Review of resident #006's RN's and PSW's TAR from an identified eight day period identified that resident #006 had a Physician prescribed two identified topical treatments to be applied to the affected areas at bedtime. Review of the MR's for resident #006 identified there was no documentation indicating that resident #006's identified topical treatments had been applied as prescribed by the Physician.

Related to resident #007:

Review of resident #007's RN's and PSW's TAR from an identified eight day period identified that resident #007 had a Physician order for an identified topical treatment to an affected area twice a day.

During an interview, PSW #110 indicated applying the treatment cream to resident #007's affected area on an identified date. Review of the MR's for resident #007 identified that there was no documentation indicating that resident #007's topical treatment had been applied as prescribed by the Physician.

During an interview, PSW #110 indicated the residents topical treatments are signed for by the PSWs on a paper TAR specific for the PSWs. PSW #110 indicated not knowing where the binder was located and had not signed for the topical treatments being applied during the identified eight day period.

During an interview, PSW #109 indicated the topical treatments are signed for by the PSWs in the Point of Care system and there is a treatment binder that is used to reference what treatment creams are required.

During an interview, RPN #102 and RPN #111 indicated registered staff and PSWs are responsible for different topical treatments and have two separate binders. RPN # 102 and RPN #111 indicated that they only sign for the residents topical treatment that they have applied using the e-MAR system or the paper copy in the RN TAR. RPN #102 and RPN #111 both indicated the PSWs sign in the TAR designated for the PSWs following the application of the resident's topical treatments.

During an interview, the Director of Care indicated that the registered staff and the PSWs are responsible to document the application of topical treatments on the applicable paper RN's or PSWs TAR following application.

Therefore, the inspector was not able to determine if resident #001, 006, and 007's medication treatments had been applied as prescribed by the Physician as there was no documentation on their MR at the time the medication treatment was applied, or by the person who administered the medication treatment as specified in the home's policy. [s. 8. (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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement.

Ontario Regulation 79/10 section 45.(2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

Related to log #005639-16:

Trent Valley Lodge is a one hundred and two bed home.

A previous compliance order (CO) was made to address the licensee's failure to comply with s. 8.(3) of the LTCH, 2007. The CO #002 was issued on March 10, 2015 on inspection #2015_396103_0014.

The home's staffing schedule for Registered Nurses was reviewed from January 28 to April 20, 2016.

There was no Registered Nurse (RN) who was an employee of the licensee and a member of the regular nursing staff or pursuant to a contract or an agreement between the nurse and the licensee present in the home on the following days: February 24, 2016 between 0600 and1400 hours; February 28, 2016 between 2200 and 0600 hours; and March 2, 2016 between 1400 and 2200 hours.

The Director of Care (DOC) was interviewed and confirmed the licensee did not have an RN on duty on the above dates. The licensee has had an RN on site from March 3, 2016 to the date of this inspection and the currently posted schedule to April 20, 2016 does not indicate any deficiencies at this time.

The DOC has been actively recruiting registered nurses and has recently hired two casual RN's. Agency RN's have been utilized when available, in accordance with the allowable exceptions.

The DOC indicated that on the three identified dates the two casual registered nurses and the agency registered nurse were not available to work due to illness and the home did not have at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty.

Therefore, the hours not covered are not the result of an "emergency" and the exemption to the requirements that at least one RN who is both an employee of the licensee and a member of the regular nursing staff are not applicable as per Ontario Regulation 79/10 section 45.(2). [s. 8. (3)]

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. (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 has failed to ensure that the provision of the care set out in resident #002, #004, #008, and #010's plan of care were documented.

Related resident #002's log #000617-16:

Review of the Critical Incident indicated that on an identified date, PSW #107 observed resident #002 touching resident 003's clothing inappropriately while sitting in an identified

public area. The immediate actions taken for resident #002 included identified interventions that included every fifteen minute checks to ensure the residents whereabouts.

Review of resident #002's plan of care for a specific period identified that resident #002 required every fifteen minute checks to ensure the resident was not displaying the identified inappropriate behaviour.

Review of resident #002's documentation for an identified three month period related to every fifteen minute wandering checks identified that from 2215 to 0600 hours on one occasion; from 0615 to 1345 hours on twenty-nine occasions; and from 1415 to 2145 hours on twenty occasions the every fifteen minutes checks were not documented as completed.

During an interview on an identified date, PSW #122 indicated that resident #002 had no further inappropriate behaviour and was not aware that resident #002 required every fifteen minute checks and was not aware of the requirement to document the checks.

Related to resident #004's log #005639-16:

Review of the Critical Incident indicated that on an identified date, PSW #109 observed resident #004 inappropriately touching resident #005 while sitting in an identified public area. The immediate actions taken for resident #004 included separating the two residents and every fifteen minute checks was initiated for resident #004 to ensure the resident was not left unsupervised in common areas.

Review of resident #004's plan of care at the time of the incident identified that resident #004 required every fifteen minute checks to ensure the resident was not displaying identified inappropriate touching with other resident's and was not left alone with other confused residents in common areas.

Review of resident #004's documentation for the 21 days following the incident related to every fifteen minute checks identified that from 2215 to 0600 hours on thirteen occasions; from 0615 to 1345 hours on thirteen occasions; and from 1415 to 2145 hours on thirteen occasions the every fifteen minutes were not documented as completed.

During an interview on an identified date, PSW #116 indicated that resident #004 had no further incidents of inappropriate touching and was not aware that resident #004 required

every fifteen minute checks and was not aware of the requirement to document the checks.

Related to resident #008:

Review of resident #008's plan of care for an identified two and a half month period identified that resident #008 required every fifteen minute checks for an identified reason.

Review of resident #008's documentation for the identified period related to every fifteen minute checks identified that between 2215 to 0600 hours on an identified date on one occasion, between 0615 to 1345 hours on twenty-seven occasions, and between 1415 to 2145 hours on seventeen occasions the every fifteen minutes were not documented as completed.

During an interview on an identified date, PSW #122 indicated not being aware that resident #008 required every fifteen minute checks and was not aware of the requirement to document the checks.

During an interview, the DOC and RN #100 identified that resident #002, #004, and #008 required every fifteen minute checks. The expectation was for the PSW's or the registered staff to document the provision of care related to the fifteen minute checks on the designated form as set out in the residents plan of care.

Related to resident #010:

Review of resident #010's Physician Orders for an identified three month period identified that resident #010's was prescribed an identified medication for a medical condition and that prior to administering the identified medication a monitoring of the resident's medical condition was required.

Review of Resident #010's 0800 hour record used to record the residents medical condition prior to administering the identified medication during the identified period indicated that there was no documented recording of the medical condition prior to administering the medication as required on seventy three occasions over a period of two months and twenty-one days.

During an interview, the DOC indicated the RPN's have been monitoring resident #010's medical condition prior to administering the identified medication but had not been

documenting in the clinical record. [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 documentation is completed for resident #002, #004, and #008's provision of care set out related to every fifteen minute checks, as required and that resident #010's medical condition is also documented as required, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's, #006's, and #007's treatment medication creams were stored in an area or a medication cart that was secure and locked.

On an identified date and time, resident #001's had six identified medicated treatment creams observed by Inspector #601 on resident #001's bathroom counter. Resident #001 indicated that the treatment creams were stored in the bathroom and the PSW's applied the resident's treatment creams, as required according to skin condition. During an interview, PSW #107 indicated that resident #001's medicated treatment creams were stored in the resident's bathroom and that the PSW's apply the treatment creams, when required.

On an identified date and time, resident #006's had three identified medicated treatment creams observed by Inspector #601 on resident #006's bedside table. During an interview, PSW #109 indicated that resident #006's medicated treatment creams were stored in the resident's bedside table and that the PSW's apply the treatment creams, when required.

On an identified date and time, resident #007's identified medicated treatment cream was observed by Inspector #601 on resident #007's bedside table. During an interview, PSW #109 indicated that resident #007's treatment creams were stored in the resident's bathroom and that the PSW's apply the treatment creams, when required.

During an interview, the DOC indicated that the resident's treatment creams were to be stored in a locked, secure room and the PSW's apply the treatment creams under the direction of the registered staff. [s. 129. (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 resident #001's, #006's, and #007's treatment medication creams are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to resident #001 in the home unless the drug has been prescribed for the resident.

Review of resident #001's Physician Order Form identified that resident #001's identified topical treatment was discontinued by the Physician on an identified date.

During an interview, resident #001 indicated the identified topical treatment had been applied to the affected area in the morning when required. Resident #001 also indicated the PSWs had applied the identified medicated topical treatment on three identified dates following the discontinuation of the medicated topical treatment.

During an interview, PSW #112 who provided morning care to resident #001 on two of the identified dates indicated applying the identified medicated topical treatment.[s. 131. (1)]

2. The licensee has failed to ensure that drugs are administered to resident #001 and #007 in accordance with the directions for use as specified by the prescriber.

Related to resident #001:

During an interview on an identified date, resident #001 indicated frustration that the agency staff do not read the plan of care and have no direction on how to apply the resident's topical treatments.

Review of resident #001's Treatment Administration Record for a ten day period, identified that resident #001 had a Physician's order to have the identified medicated topical treatment applied to a specified area at bedtime.

During an interview, resident #001 indicated the identified medicated topical treatment was applied to the specified area by the PSW at bedtime when required.

During an interview, PSW #109 indicated that resident #001 had not recently required the topical treatment to the specified area. Review of the PSW Flow Sheet documentation for a seven day period for resident #001 identified that PSW #109 provided evening care for resident #001 on four occasions during this period of time.

Review of Resident #001's Treatment Administration Record identified that there was no documentation indicating that resident #001's identified topical treatment was applied to specified area at bedtime, as prescribed by the Physician.

Therefore, on four identified dates PSW #109 provided care to resident #001 and indicated that the identified topical treatment was not applied at bedtime, as prescribed by the Physician.

Related to resident #007:

Review of resident #007's Physician Orders identified that resident #007's Physician ordered an identified medicated topical treatment to be applied to specified area twice a day.

During an interview, PSW #109 indicated that resident #007's topical treatment had not been required recently and is only applied when resident #007's required. Review of the PSW Flow Sheet documentation for a seven day period for resident #007 identified that PSW #109 provided evening care to resident #007 on three occasions during the identified period of time.

During an interview, RPN #111 indicated that resident #007 did not require a medicated topical treatment and was not currently being applied to resident #007's.

Review of resident #007's PSW's Treatment Administration Record and electronic Medication and Treatment Administration record for a ten day period identified that

resident #007's identified medicated topical treatment scheduled to be applied to specified area at 1000 and 1900 hours had not been documented as administered.

Therefore, RPN #111 who was responsible to monitor the administration of resident #007's medicated topical treatment was not aware of the Physician order to apply the topical treatment to resident #007's specified area twice a day. PSW #109 who was responsible for resident #007's care on three identified dates indicated the topical treatment had not been applied, as prescribed by the Physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to resident #001 in the home unless the drug has been prescribed for the resident and that resident #001, #006, #007's treatment creams are applied as prescribed, to be implemented voluntarily.

Issued on this 6th day of May, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KARYN WOOD (601)
Inspection No. / No de l'inspection :	2016_389601_0005
Log No. / Registre no:	003982-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 18, 2016
Licensee / Titulaire de permis :	TRENT VALLEY LODGE LIMITED 195 Bay Street, TRENTON, ON, K8V-1H6
LTC Home / Foyer de SLD :	TRENT VALLEY LODGE LIMITED 195 BAY STREET, TRENTON, ON, K8V-1H9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BILL WEAVER JR

To TRENT VALLEY LODGE LIMITED, 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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall:

(a) educate all registered nursing staff about the licensee's Policy #TC-1022.2 General Considerations Administration of Medication General Guideline in a formal education session, and evaluate staff comprehension of the contents of the policy following the session; in particular the session and evaluation must include the requirement in the policy to administer medication within one hour of the scheduled time and that medication including treatment creams are documented at the time the medication is given; and

(b) educate all registered nursing staff and all staff who apply treatment creams related to the College of Nurses of Ontario Medication Practice Standard, including the administration of medication and treatment creams to be given according to the scheduled times as prescribed by the Physician, the management of medication errors, and appropriate actions to be taken in response to medication errors; and

(c) develop and implement a process to ensure that all staff who administer medication and medicated treatment creams to residents adhere to the licensee's Policy #TC-1022.2 General Considerations Administration of Medication General Guideline and the College of Nurses of Ontario Medication Practice Standard, and ensure that prompt action is taken in response to non-compliance with this policy.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that their policy related to medication administration was followed to ensure safe, effective administration of medication for resident #001, #006, #009, and #010.

Related to log #003982:

O. Reg. 79/10, 114. (2) states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure that accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Review of the licensee's Administration of Medications - General Considerations Policy number TC-1022.2 indicated that medications are administered within one hour of the scheduled time, except medications to be given with food, or before

or after meal/food orders, which are administered precisely as ordered. If there is a question about the specific time a medication should be given, consult with the consultant pharmacist or pharmacy provider.

Review of the licensee's electronic medication system identified that the administering nurse signs for the residents medication on the e-MAR and e-TAR system. The e-MAR and e-TAR system records the actual time that the residents medication was signed as administered by the nurse on the Medication Treatment Administration Record.

Related to resident #001:

During an interview, resident #001 indicated that medication is not always administered according to the scheduled times.

Review of resident #001's Medication Treatment Administration Record for an identified two months and twenty-one day period identified that resident #001's medication scheduled to be administered included five identified medication to be administered at 0800 hour and two identified medication to be administered at 2000 hours.

It was identified that resident #001's 0800 hour medication were administered greater than one hour following the administration scheduled time on fifty-four occasions ranging from eighteen minutes to one hour and twenty-six minutes late during the identified period of two months and twenty-one days.

It was identified that resident #001's 2000 hour medication were administered greater than one hour following the administration scheduled time on forty-three occasions ranging from nine minutes to one hour and thirty-nine minutes late during the identified period of two months and twenty-one days.

Review of resident #001's Physician Orders and the Medication/Treatment Administration Record for an identified two months and twenty-one day period identified that resident #001 had a Physician order for an identified medication to be applied at 0800 hour and to be removed at 2000 hour.

During the identified period of two months and twenty-one days, resident #001's identified medication that was scheduled for 0800 hours was not administered within one hour of the scheduled time on fifty-four occasions and the identified

medication that was scheduled to be removed at 2000 hours was not removed within one hour of the scheduled time on forty-three occasions. It was identified that the identified medication remained on resident #001 greater than twelve hours on twelve occasions during the period of two months and twenty-one days.

During an interview, Pharmacist #105 indicated that resident #001's identified medication should be applied according to the home's policy for medication administration at 0800 and to be removed at 2000 hours. According to Pharmacist #105, resident #001's identified medication should be in place for at least eight hours to ensure appropriate absorption of the medication or should not be in place greater than twelve hours due to the potential risk of increased absorption of the medication.

During the identified period of two months and twenty-one days resident #001's identified medication was not applied within one hour of the scheduled time on fifty-four occasions and was not removed within one hour of the scheduled time on forty-three occasions during the identified time period. There was a potential risk of resident #001 having an increased absorption of the identified medication due to the medication being in place for greater than twelve hours on twelve occasions.

Related to resident #006:

Review of resident #006's Medication Treatment Administration Record for an identified period of two months and twenty-one days identified that resident #006's medication scheduled to be administered included eight identified medication at 0800 hours, one identified medication at 1200 hours, and four identified medication at 1700 hours.

It was identified that resident #006's 0800 hour medications were administered greater than one hour following the administration scheduled time on thirty-seven occasions ranging from five minutes to three hours and sixteen minutes late during an identified two month and twenty-one day period.

It was identified that resident #006's 1700 hour medications were administered greater than one hour following the administration scheduled time on twenty-nine occasions ranging from three minutes to fifty-four minutes late during an identified two month and twenty-one day period.

During an interview, Pharmacist #105 indicated resident #006's medications should be given according to the home's policy for medication administration and when a medication is ordered for three times a day the scheduled times are 0800, 1200, and 1700 hours. Pharmacist #105 also indicated that resident #006's identified medication should be given at the scheduled times because the identified medication peak concentration levels are usually one to three hours after administration. According to Pharmacist #105, when resident #006's 0800 hour identified medication was administered after 0900 hours it could have caused the identified medication that was administered at 1200 hours to peak at the same time temporarily increasing resident #006's blood level.

Therefore, during the period of two months and twenty-one days resident #006's identified medication was not administered within an hour of the scheduled time on sixty-six occasions.

Related to resident #009:

Review of resident #009's Medication Treatment Administration Record for an identified period of two months and twenty-one days identified that resident #009's medication was scheduled to be administered included seven identified medication at 0800hour, one identified medication at 1200 hours, and two identified medication at 1700 hours.

It was identified that resident #009's 0800 hour medications were administered greater than one hour following the administration scheduled time on twenty-nine occasions ranging from four minutes to one hour and fifty-two minutes late during the identified period of two months and twenty-one days.

It was identified that resident #009's 1200 hour medication were administered greater than one hour following the administration scheduled time on twenty occasions ranging from five minutes to forty-seven minutes late during the identified period of two months and twenty-one days.

During an interview, Pharmacist #105 indicated that resident #009's identified medication should be given according to the home's policy for medication administration at 0800 and 1200 hours. According to Pharmacist #105, resident #009's identified medication administered after 0900 hours could potentially increase resident #009's risk for identified medical conditions due to receiving

the next dose at 1200 hours.

Therefore, during the identified period of two months and twenty-one days resident #009's identified medication was not administered within an hour of the scheduled time on thirty-one occasions potentially increasing resident #009's risk for identified medical conditions.

Related to resident #010:

Review of resident #010's Medication Treatment Administration Record for an identified period of two months and twenty-one days identified that resident #010's medication scheduled to be administered included fifteen identified medication at 0800 hours, two identified medications at 1200 hours, four identified medication at 1700 hours, and two identified medication at 2000 hours.

It was identified that resident #010's 0800 hour medications were administered greater than one hour following the administration scheduled time on fifty-five occasions ranging from fourteen minutes to one hour and forty-one minutes late during an identified period of two months and twenty-one days.

It was identified that resident #010's 1200 hour medications were administered greater than one hour following the administration scheduled time on six occasions ranging from ten minutes to thirty-nine minutes late during an identified period of two months and twenty-one days.

It was identified that resident #010's 1700 hour medications were administered greater than one hour following the administration scheduled time on three occasions ranging from nine minutes to twenty-four minutes late during an identified period of two months and twenty-one days.

It was identified that resident #010's 2000 hour medications were administered greater than one hour following the administration scheduled time on twenty-three occasions ranging from six minutes to one hour and twenty-eight minutes late during an identified period of two months and twenty-one days.

Resident #010 has an identified diagnosis that required two specific medications to manage the symptoms of the medical condition.

During an interview, Pharmacist #105 indicated that resident #010's identified

medication should be given at regular intervals to manage medical condition.

Therefore, during the identified period of two months and twenty-one days resident #0010's identified medication to manage the residents medical condition included identified medication that was not administered within an hour of the scheduled time on eighty-seven occasions. Resident #010's second identified medication was not administered within an hour of the scheduled time on fifty-five occasions.

Inspector #601 observed RPN #106 administer medication for resident #006, #009, #010 and noted that RPN #106 signed on the e-MAR system for the medication provided immediately following administration.

During an interview, RPN #106 indicated that all medication administered to residents were signed on the e-MAR system immediately following medication administered. RPN #106 also indicated that the residents who go to the dining room for breakfast receive their medication prior to the residents who remain in their room for breakfast. RPN #106 also indicated that the registered staff assist with meal service and attend a morning meeting prior to completing the 0800 hour medication pass.

During an interview, the DOC indicated not being aware that the registered staffs were not administering the medication within one hour of the scheduled time as specified in the policy and that medication should be given according to the policy. [s. 8. (1) (b)]

2. Review of the licensee's Administration of Medications - General Considerations Policy number TC-1022.2 indicated medication administration is documented on the resident's medication record (MR), at the time the medication is given, by the person who administered the medication. The resident's Medication Record is signed by the person administering a medication electronically or in the space provided under the date, and on the line for that specific medication dose. Initials on the Medication Record are verified with a full signature in the space provided.

Related to resident #001:

During an interview, resident #001 indicated that an identified topical treatment had been applied to a specified area every night when there was an identified

reason and a different topical treatment was applied by the PSW during morning care on an identified date. Resident #001 also indicated the PSW's apply another identified topical treatment to an identified area morning and night.

Review of resident #001's RN's and PSW's Treatment Administration Record (TAR) during an identified eight day period identified that resident #001 Physician had prescribed two identified topical treatments to be applied as required and one identified topical treatment to be applied at bedtime.

During an interview, RPN #117 indicated that resident #001 would be capable of recalling when the topical treatment had been applied. Review of Medication Records's for resident #001 identified there was no documentation indicating that resident #001's identified topical treatment had been applied as prescribed by the Physician or as identified by resident #001.

Related to resident #006:

Review of resident #006's RN's and PSW's TAR from an identified eight day period identified that resident #006 had a Physician prescribed two identified topical treatments to be applied to the affected areas at bedtime. Review of the MR's for resident #006 identified there was no documentation indicating that resident #006's identified topical treatments had been applied as prescribed by the Physician.

Related to resident #007:

Review of resident #007's RN's and PSW's TAR from an identified eight day period identified that resident #007 had a Physician order for an identified topical treatment to an affected area twice a day.

During an interview, PSW #110 indicated applying the treatment cream to resident #007's affected area on an identified date. Review of the MR's for resident #007 identified that there was no documentation indicating that resident #007's topical treatment had been applied as prescribed by the Physician.

During an interview, PSW #110 indicated the residents topical treatments are signed for by the PSWs on a paper TAR specific for the PSWs. PSW #110 indicated not knowing where the binder was located and had not signed for the topical treatments being applied during the identified eight day period.

During an interview, PSW #109 indicated the topical treatments are signed for by the PSWs in the Point of Care system and there is a treatment binder that is used to reference what treatment creams are required.

During an interview, RPN #102 and RPN #111 indicated registered staff and PSWs are responsible for different topical treatments and have two separate binders. RPN # 102 and RPN #111 indicated that they only sign for the residents topical treatment that they have applied using the e-MAR system or the paper copy in the RN TAR. RPN #102 and RPN #111 both indicated the PSWs sign in the TAR designated for the PSWs following the application of the resident's topical treatments.

During an interview, the Director of Care indicated that the registered staff and the PSWs are responsible to document the application of topical treatments on the applicable paper RN's or PSWs TAR following application.

Therefore, the inspector was not able to determine if resident #001, 006, and 007's medication treatments had been applied as prescribed by the Physician as there was no documentation on their MR at the time the medication treatment was applied, or by the person who administered the medication treatment as specified in the home's policy. [s. 8. (1) (b)]

The non-compliance with O. Reg. 79/10, s. 8(1)(b), O.Reg. 79/10, 114. (2) order is being issued based on the fact that the Administration of Medication – General Consideration Policy #TC-1022.2 was not complied with. During the compliant inspection initiated on March 8, 2016 it was identified that four out of four residents including resident #001 on ninety-seven occasions, #006 on sixty-six occasions, #009 on forty-nine occasions, and #010 on eight-seven occasions in relation to medications not being administered within one hour of the scheduled time for the residents. Therefore, there is a risk that the resident's medications scheduled for 0800 and 1200 hours could potentially be given to close together with potential adverse side effects for the residents identified. It was also identified that from March 1 to 21, 2016 three out of three residents with a Physician order for medication treatment creams including resident #001, #006, and #007 did not have documentation on the residents Medication Record at the time the medication was given, or by the person who administered the medication treatment cream as specified in the policy. Therefore, there is a risk of medication treatment creams not being applied as prescribed and a potential

for medication dispensing errors as staff had not documented the medication treatment creams being applied as prescribed by the Physician. In addition, the compliance history of the licensee includes an order being issued for O. Reg. 79/10, s.134 on March 10, 2015 in a similar area related to monitoring and documentation of pain management. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall:

a) ensure that at least one registered nurse is on duty and present in the home at all times; and

b) ensure the staffing plan is reviewed to ensure additional back up is available in accordance with the exceptions provided in O. Reg. 79/10 s. 45 (2) when registered nurse coverage is not available.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement.

Ontario Regulation 79/10 section 45.(2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

Regarding log #005639-16:

Trent Valley Lodge is a one hundred and two bed home.

A previous compliance order (CO) was made to address the licensee's failure to comply with s. 8.(3) of the LTCH, 2007. The CO #002 was issued on March 10,

2015 on inspection #2015_396103_0014.

The home's staffing schedule for Registered Nurses was reviewed from January 28 to April 20, 2016.

There was no Registered Nurse (RN) who was an employee of the licensee and a member of the regular nursing staff or pursuant to a contract or an agreement between the nurse and the licensee present in the home on the following days: February 24, 2016 between 0600 and1400 hours; February 28, 2016 between 2200 and 0600 hours; and March 2, 2016 between 1400 and 2200 hours.

The Director of Care (DOC) was interviewed and confirmed the licensee did not have an RN on duty on the above dates. The licensee has had an RN on site from March 3, 2016 to the date of this inspection and the currently posted schedule to April 20, 2016 does not indicate any deficiencies at this time.

The DOC has been actively recruiting registered nurses and has recently hired two casual RN's. Agency RN's have been utilized when available, in accordance with the allowable exceptions.

The DOC indicated that on the three identified dates the two casual registered nurses and the agency registered nurse were not available to work due to illness and the home did not have at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty.

Therefore, the hours not covered are not the result of an "emergency" and the exemption to the requirements that at least one RN who is both an employee of the licensee and a member of the regular nursing staff are not applicable as per Ontario Regulation 79/10 section 45.(2).

The non-compliance with the LTCHA, 2007 S.O. 2007, c.8, s.8. (3) order is being issued based on the fact that on three occasions for an eight hour period of time the licensee did not ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times. In addition, the compliance history includes a compliance order issued on March 10, 2015 in the same area. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 18th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Karyn Wood

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