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**

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JESSICA LAPENSEE (133) |
| **Inspection No. / No de l'inspection :** | 2013_204133_0015 |
| **Log No. / Registre no:** | S-001359-12, S-000065-13 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Jul 29, 2013 |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2 |
| **LTC Home / Foyer de SLD :** | LAKEHEAD MANOR<br>135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jonathon Riabov |

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) (b)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

**Order / Ordre :**

The licensee will prepare, submit and implement a plan for achieving compliance with the requirement that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. The plan must address how this will be accomplished with full time, part time and casual staff who provide direct care to a resident. The plan will include, but not be limited to, a specific focus on resident's who are infected with, or carriers of, antibiotic resistant organisms such as Extended Spectrum Beta Lactamase (ESBL) producing bacteria and Methicillin Resistant Staphylococcus Aureus (MRSA). The licensee will ensure that the resident's plan of care clearly identifies such infections and/or carrier status, including infected/affected site and infectious body substances (ie. urine, feces, nasal secretions). The plan must address how management staff will regularly ascertain that all staff who provide direct care to a resident are kept aware of the contents of the residents' plans of care and that they have convenient and immediate access to it. This process must be documented so as to allow for follow up.

The plan is to be submitted in writing to Long Term Care Home inspector Jessica Lapensee at 347 Preston Street, 4th floor, Ottawa, Ontario, K1S 3J4. Alternately, the plan may be faxed to the inspector's attention at (613) 569-9670. The plan is due by August 5th, 2013. Full compliance with this Compliance Order is required by August 30th, 2013.

**Grounds / Motifs :**

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6 (8)

in that nursing staff members were not aware of the contents of two residents' plans of care. Specifically, registered and non-registered nursing staff involved with the care of the resident #001 and resident #002 were not aware of why the residents were on enhanced infection control precautions.

The inspector reviewed resident #001's plan of care during the inspection, June 11th-14th 2013. Resident #001's care plan highlights that the resident is infected with an Antibiotic Resistant Organism (ARO). As a result of this infection, some types of resident #001's body fluids are a potential source of contamination with the ARO. Resident #001 is on contact precautions and personal protective equipment is available outside of the resident's bedroom for staff to use as needed.

On June 13th 2013, during the inspection, the inspector spoke with non-registered nursing staff member #S100 outside of resident #001's bedroom and asked why resident #001 was on contact precautions. Staff member #S100 said they didn't know why resident #001 was on contact precautions. Staff member explained that they are a part time worker, and that they have not worked on resident #001's care unit for a month. It is noted that resident #001 has been on contact precautions due to their ARO status since at least March 2013.

On June 14th 2013, during the inspection, the inspector spoke with a member of the housekeeping department, staff #S101, in front of resident #001's bedroom. The inspector asked staff member #S101 if they knew why resident #001 was on contact precautions. Staff person #S101 explained that they work between all care units and that they are not immediately familiar with resident #001 and why they may be on contact precautions. Staff person #S101 said that they leave "isolation rooms" to the last and would normally speak with the unit Registered Practical Nurse (RPN) before going into such a room so they could be instructed. The inspector then went to speak with the unit RPN, staff member #S102 and asked why resident #001 was on contact precautions. Staff member #S102 said they thought it was "MRSA, or one of those things" (MRSA = methicillin-resistant staphylococcus aureus, a different type of ARO). Several minutes later, the inspector met staff member #S102 again who enquired if the inspector had found out why resident #001 was on contact precautions. The inspector told staff member #S102 that resident #001 was on contact precautions because they were infected with certain type of ARO. The inspector asked staff member #S102 if they knew how this type of ARO was spread. Staff

member #S102 indicated they thought the ARO was spread through skin to skin contact. The ARO in question is not spread by skin to skin contact.

On June 14th 2013, during the inspection, the inspector spoke with non-registered nursing staff member #S103, about resident #001, while at the care unit nursing station. The inspector asked staff person #S103 if they knew why resident #001 was on contact precautions. Staff person #S103 indicated that they thought the cause of the contact precautions was related to the resident's bowels, but was unsure as to what resident #001 was infected with.

The inspector reviewed resident #002's plan of care during the inspection, June 11th-14th 2013. Resident #002's care plan highlights that the resident is infected with an ARO. It is the same ARO that affects resident #001. As a result of this infection, some types of resident #001's body fluids are a potential source of contamination with the ARO. Resident #002 is on contact precautions and personal protective equipment is available outside of the resident's bedroom for staff to use as needed.

On June 13th 2013, during the inspection, the inspector spoke with non-registered nursing staff member #S104 outside of resident #002's bedroom and asked why resident #002 was on contact precautions. Staff member #S104 replied that they did not know why, and explained that they are a part time worker, and that they rarely work on resident #002's care unit. The inspector then went to speak with the unit RPN, staff member #S105 and asked why resident #002 was on contact precautions. Staff member #S105 replied that resident #002 is on contact precautions because they are infected with MRSA (MRSA = methicillin-resistant staphylococcus aureus, a different type of ARO), but that they did not know the affected site. Staff member #S105 explained that they are a part time worker, and typically do not work on resident #002's care unit. Resident #002 is not infected with MRSA.

On June 14th 2013, during the inspection, the inspector spoke with non-registered nursing staff member #S106 outside of resident #002's bedroom and asked why resident #002 was on contact precautions. Staff member #S106 replied that they thought it was because resident #002 was infected with a parasite. Residents #002 is not infected with a parasite.

This widespread lack of awareness of the contents of two identified residents'

plans of care presents a risk to all residents as staff do not know that certain types of the identified resident's body fluids are potential sources of ARO contamination and infection transmission.

It is noted that non compliance has been found with LTCHA, 2007, S.O. 2007, c. 8, s.6(8) in the home's compliance history. A written notification was issued to the home in this section and subsection on February 23, 2012 as a result of inspection # 2011_051106_0015. A second written notification was issued to the home on February 24, 2012 as a result of inspection #2011_051106_0016. As well, concerns, specifically related to nursing staff members lack of knowledge about an ARO (the same type) were addressed in a Compliance Order (#910), pursuant to O. Reg. 79/10, s.229(8), issued to the home on October 15th 2012 as a result of inspection 2012_053122_0014. [s. 6. (8)] (133)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 30, 2013

## 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 29th day of July, 2013**

**Signature of Inspector / Signature de l'inspecteur :** Linda Foster, Manager for/

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

**Service Area Office / Bureau régional de services :** Sudbury Service Area Office

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**

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 29, 2013 | 2013_204133_0015 | S-001359-12, S-000065-13 | Follow up |

**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**

LAKEHEAD MANOR
135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2

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

JESSICA LAPENSEE (133)

**Inspection Summary/Résumé de l'inspection**

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**

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

**This inspection was conducted on the following date(s): June 11th - 14th 2013**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Resident Services Coordinator, The Regional Manager of Clinical Services, the Nursing Secretary, Registered and Non- Registered nursing staff, a member of housekeeping services department.**

**During the course of the inspection, the inspector(s) reviewed minutes from the home's first meeting of the Infection Control committee of May 2013; reviewed the health care record of 10 residents with a focus on Tuberculosis screening post admission; reviewed infection prevention and control related policies; reviewed the health care record of several residents with a focus on current infection status; inspected residents' bedrooms with a focus on privacy curtains.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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.) | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | 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 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6(1)c in that a resident's plan of care does not provide clear direction to staff and others who provide direct care to the resident.

While reviewing resident #003's health care record on June 14th 2013, during the inspection, the inspector found a lab result that indicated that resident #003 is infected with an Antibiotic Resistant Organism (ARO). The inspector reviewed the resident's care plan document and found that it has not been updated to reflect that resident #003 is infected with the ARO. Apart from the lab result, the inspector did not find any other reference to resident #003's ARO status within the resident's health care record. Given this omission, the plan of care does not provide clear direction to staff on how to care for the resident in light of this infection.

It is noted that non compliance has been found with LTCHA, 2007, S.O. 2007, c.8, s (6)1.c. in the home's compliance history. A written notification was issued to the home on February 24, 2012, as a result of inspection # 2011_051106_0014. A written notification with a voluntary plan of correction was issued to the home on May 23, 2012, as a result of inspection #2012_104196_0009. A written notification with a voluntary plan of correction was also issued to the home in July 2012 as a result of inspection #2012_053122_0009. As well, concerns, specifically related to a lack of direction to staff, in the plan of care, about a resident's ARO status (the same type of ARO), were addressed in a Compliance Order (#910), pursuant to O. Reg. 79/10, s.229(8), issued to the home on October 15th 2012 as a result of inspection 2012_053122_0014. [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6 (8) in that nursing staff members were not aware of the contents of two residents' plans of care. Specifically, registered and non-registered nursing staff involved with the care of the resident #001 and resident #002 were not aware of why the residents were on enhanced infection control precautions.

The inspector reviewed resident #001's plan of care during the inspection, June 11th-14th 2013. Resident #001's care plan highlights that the resident is infected with an Antibiotic Resistant Organism (ARO). As a result of this infection, some types of resident #001's body fluids are a potential source of contamination with the ARO. Resident #001 is on contact precautions and personal protective equipment is available outside of the resident's bedroom for staff to use as needed.

On June 13th 2013, during the inspection, the inspector spoke with non-registered nursing staff member #S100 outside of resident #001's bedroom and asked why resident #001 was on contact precautions. Staff member #S100 said they didn't know why resident #001 was on contact precautions. Staff member explained that they are a part time worker, and that they have not worked on resident #001's care unit for a month. It is noted that resident #001 has been on contact precautions due to their ARO status since at least March 2013.

On June 14th 2013, during the inspection, the inspector spoke with a member of the housekeeping department, staff #S101, in front of resident #001's bedroom. The inspector asked staff member #S101 if they knew why resident #001 was on contact precautions. Staff person #S101 explained that they work between all care units and that they are not immediately familiar with resident #001 and why they may be on contact precautions. Staff person #S101 said that they leave "isolation rooms" to the last and would normally speak with the unit Registered Practical Nurse (RPN) before going into such a room so they could be instructed. The inspector then went to speak with the unit RPN, staff member #S102 and asked why resident #001 was on contact precautions. Staff member #S102 said they thought it was "MRSA, or one of those things" (MRSA = methicillin-resistant staphylococcus aureus, a different type of ARO). Several minutes later, the inspector met staff member #S102 again who enquired if the inspector had found out why resident #001 was on contact precautions. The inspector told staff member #S102 that resident #001 was on contact precautions because they were infected with certain type of ARO. The inspector asked staff member #S102 if they knew how this type of ARO was spread. Staff member #S102 indicated they thought the ARO was spread through skin to skin contact. The ARO in question is not spread by skin to skin contact.

On June 14th 2013, during the inspection, the inspector spoke with non-registered nursing staff member #S103, about resident #001, while at the care unit nursing station. The inspector asked staff person #S103 if they knew why resident #001 was on contact precautions. Staff person #S103 indicated that they thought the cause of the contact precautions was related to the resident's bowels, but was unsure as to what resident #001 was infected with.

The inspector reviewed resident #002's plan of care during the inspection, June 11th-14th 2013. Resident #002's care plan highlights that the resident is infected with an

ARO. It is the same ARO that affects resident #001. As a result of this infection, some types of resident #001's body fluids are a potential source of contamination with the ARO. Resident #002 is on contact precautions and personal protective equipment is available outside of the resident's bedroom for staff to use as needed.

On June 13th 2013, during the inspection, the inspector spoke with non-registered nursing staff member #S104 outside of resident #002's bedroom and asked why resident #002 was on contact precautions. Staff member #S104 replied that they did not know why, and explained that they are a part time worker, and that they rarely work on resident #002's care unit. The inspector then went to speak with the unit RPN, staff member #S105 and asked why resident #002 was on contact precautions. Staff member #S105 replied that resident #002 is on contact precautions because they are infected with MRSA (MRSA = methicillin-resistant staphylococcus aureus, a different type of ARO), but that they did not know the affected site. Staff member #S105 explained that they are a part time worker, and typically do not work on resident #002's care unit. Resident #002 is not infected with MRSA.

On June 14th 2013, during the inspection, the inspector spoke with non-registered nursing staff member #S106 outside of resident #002's bedroom and asked why resident #002 was on contact precautions. Staff member #S106 replied that they thought it was because resident #002 was infected with a parasite. Residents #002 is not infected with a parasite.

This widespread lack of awareness of the contents of two identified residents' plans of care presents a risk to all residents as staff do not know that certain types of the identified resident's body fluids are potential sources of ARO contamination and infection transmission.

It is noted that non compliance has been found with LTCHA, 2007, S.O. 2007, c. 8, s.6(8) in the home's compliance history. A written notification was issued to the home in this section and subsection on February 23, 2012 as a result of inspection # 2011_051106_0015. A second written notification was issued to the home on February 24, 2012 as a result of inspection #2011_051106_0016. As well, concerns, specifically related to nursing staff members lack of knowledge about an ARO (the same type) were addressed in a Compliance Order (#910), pursuant to O. Reg. 79/10, s.229(8), issued to the home on October 15th 2012 as a result of inspection 2012_053122_0014. [s. 6. (8)]

***Additional Required Actions:***

***CO # - 001 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 with the requirement that residents' plans of care provide clear direction to staff and others who provide direct care to the residents, with a specific focus on identifying that a resident has been identified as infected with, or is a carrier of, an antibiotic resistant organism, to be implemented voluntarily.***

**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/**
**LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

COMPLIED NON COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 13. | CO #002 | 2013_204133_0004 | 133 |
| O.Reg 79/10 s. 229. (10) | CO #903 | 2012_053122_0014 | 133 |
| O.Reg 79/10 s. 229. (2) | CO #911 | 2012_053122_0014 | 133 |
| O.Reg 79/10 s. 229. (8) | CO #910 | 2012_053122_0014 | 133 |

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**

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**Issued on this 29th day of July, 2013**

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

Linda Jones, Manager for/ Jessica Lapensee