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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Jul 10, 2014;	2014_205129_0001 (A2)	H-000888-13,H-000561-13	Complaint

Licensee/Titulaire de permis

HALTON HEALTHCARE LTC INC.
327 REYNOLDS STREET, OAKVILLE, ON, L6J-3L7

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

WYNDHAM MANOR LONG TERM CARE CENTRE
291 REYNOLDS STREET, OAKVILLE, ON, L6J-3L5

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

PHYLLIS HILTZ-BONTJE (129) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 2, 3, 7, 8, 9, 10, 15 and 16, 2014

A CIS inspection was conducted concurrently. Inspection #2014_205129_002/2014_275536_002

During the course of the inspection, the inspector(s) spoke with a resident,the Executive Director,the Director of Care,the Environmental Manager,the Behavioural Support staff, registered and unregulated nursing staff in relation to Log #H-000888-13, H000219-13, H-000319-13 and H000669-13, H000561-13

During the course of the inspection, the inspector(s) toured the home and reviewed the home's investigation notes, employee files, clinical documentation, medical records, policies and procedures which included: [Resident Death Policy], [Pronouncing Resident Death], [Responsive Behaviours]and[Abuse Policy]

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan, in relation to the following: [6(7)]
Care as specified in the plan of care was not provided to resident #007 on an identified date which resulted in an altercation between the resident and a care provider during which the resident received two injuries. Care specified in the plan indicated that the resident preferred to get up between seven and eight in the morning, the resident refused to have incontinent products changed at night, staff were to assist the resident with care when the resident insisted on being independent and staff were to allow for flexibility in activities of daily living routines to accommodate the resident's moods. The staff person providing care on the identified date confirmed that she got the resident up at 0530hrs for morning care because that was the staff's routine, the resident walked to the washroom where the resident swatted the staff person's hand away as the staff person began to remove the resident's incontinent product, the resident then pulled down the incontinent product and sat on the toilet, the staff person then began to remove the incontinent product from around the resident's ankles when the resident grabbed the staff person's hair. The resident received the skin injuries when the staff person attempted to release the resident's hold on her hair. This staff person confirmed that she did not provide care as was directed in the plan of care, was aware the resident could be resistive, but was unaware of the directions in the care plan related to the time the resident gets up, the requirement to be flexible in scheduling care related to the resident's mood, that the resident's refusal to have incontinent products changed at night and that the resident prefers to perform tasks themself and staff were to support this approach. [s. 6. (7)]

2. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change, in relation to the following: [6(10) (b)]

a)Resident # 007 was not reassessed and the care plan was not reviewed or revised when documentation indicated the resident began demonstrating an increase in responsive behaviours.
-Data collected on the Minimum Data Set (MDS) review completed on March 28, 2013 indicated the resident demonstrated no responsive behaviours.
-Data collected on the following MDS review completed on June 19, 2013 indicated that responsive behaviours being demonstrated had increased and the resident was now demonstrating four responsive behaviours one to three days out of seven days. The care plan in place at this time did not include care directions for staff in relation to two of the responsive behaviours being demonstrated and staff documented that there

had been no change in the behaviours being demonstrated.
-Data collected on the following MDS completed on September 11, 2013 indicated the responsive behaviours had increased and escalated. Documentation indicated three of the responsive behaviours had increased in frequency and an additional responsive behaviour was being demonstrated on four to six out of seven days. There had been no changes made to the care plan following this review and staff documented that the behaviours had not changed.
-The Executive Director and the staff person responsible for coordinating the responsive behaviour program in the home confirmed they had knowledge that this resident demonstrated responsive behaviours, the data collected would indicate that the resident's care needs had changed over the identified period of time and that staff had not reassessed the resident and did not review and revise the plan of care to reflect this change in care needs.

b) Resident #004's care needs changed, however, the resident was not reassessed and the plan of care was not reviewed and revised.
-Data collected on the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) review completed August 18, 2013 indicated that the resident demonstrated a responsive behaviour.
-Data collected on the following MDS review dated November 10, 2013 indicated that resident's behavioural symptoms were worsening. The previously identified responsive behaviour was now being demonstrated four to six days out of seven days and three new responsive behaviours were now being demonstrated. The Resident Assessment Protocol (RAP) completed following this MDS review did not indicate that there was a change in behaviour and the resident was not reassessed in relation to changing behaviours. The care plan developed for this resident following the above noted MDS was not reviewed or revised and did not contain information that this resident was exhibiting any behaviours.
-The staff person responsible for coordinating the responsive behaviour program in the home confirmed, the data collected would indicate that the resident's care needs had changed over the identified period of time and that staff had not assessed the resident and did not review and revise the plan of care to reflect this change in care needs.

(PLEASE NOTE: This evidence of non-compliance related to reassessment and revision of care plan were found during Inspection #2014_275536_0002 / H-000859-13, H-000918-13) [s. 6. (10) (b)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001,002

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. A person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to a resident did not immediately report the suspicion and the information upon which it is based to the Director, in relation to the following: [24(1) 2]
The Director was not immediately notified following a report of abuse involving resident #009. A Personal Support Worker(PSW)submitted a letter to the Director of Care indicating that on two occasions an identified co-worker hit resident #009 and spoke inappropriately to the resident when this resident would not co-operate with the care the staff person was attempting to provide. The letter also identified a second incident involving the same co-worker forcing the same resident to receive care even though the resident was resisting the care. The Director of Care indicated in notes provided by the home that the staff person accused of these incidents was suspended pending an investigation, but did not immediately notify the Director of the suspicion that the resident had been abuse. The Director was notified of this suspicion that a resident had been abused the following day when a telephone call was placed to the Hamilton Service Area Office.
(PLEASE NOTE: This evidence of non-compliance related to the failure to immediately report a suspicion of resident abuse to the Director was found during Inspection #2014_205129_0002 / H-000859-13, H-000918-13)

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 003

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a sufficient supply of clean towels were always available in the home for use by the residents, in relation to the following: [89(1)(b)] Direct care staff confirmed that there were not sufficient clean towels available in the home to meet the care requirements of the residents. Sixteen resident's rooms were monitored on four resident home areas and no towels were noted in ten of those rooms. Linen carts on the resident home areas did not have sufficient towels available. The housekeeping manager confirmed that there have been several complaints from care staff related to the availability of towels for resident care and the linen carts prepared in the laundry area for transportation to the home areas were not stocked with a sufficient quantity of towels to meet the care needs of residents. [s. 89. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 004

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on , at a minimum, interdisciplinary assessment of the mood and behaviour patterns, including wandering, any identified responsive behaviours, and potential behavioural triggers and variations in resident functioning at different times of the day, with respect to the following: [26(3) 5]
a)The plan of care for resident #007 was not based on an interdisciplinary assessment of behaviour patterns. Clinical documentation indicated that this resident demonstrated five responsive behaviours; however, these behaviours were not assessed by the interdisciplinary team. The registered staff person responsible for the coordination of the responsive behaviour program in the home confirmed that behavioural assessments for resident #007 were not completed and she was unaware that the resident was demonstrating these behaviours. This staff person indicated that she reviewed the progress notes written to determine those residents who are demonstrating responsive behaviours and then would coordinate with staff to ensure assessments are completed. This staff person confirmed she was unaware that resident #007 was demonstrating responsive behaviours because progress notes for this resident were not identified as a behavioural notes and as a result the behaviours were not flagged for her. There was no evidence in the clinical record that an assessment of these behaviours had been completed.

b) Resident #004's plan of care was not based on an interdisciplinary assessment in relation to: mood and behaviour patterns, including responsive behaviours, any potential behaviour triggers and variations in residents functioning at different times of day. The clinical record indicated that this resident demonstrated six responsive behaviours.
Registered Staff and the staff person responsible for coordinating the responsive behaviour program in the home were unaware that the resident was demonstrating these behaviours or the need to complete an assessment. PSW's providing care to the resident would communicate each shift about behaviours and then would document those behaviours on the care flow sheets. A review of the care flow sheets indicated registered staff had not signed 117 out of 168 shifts over a two month period

and as a result were not aware that the resident was demonstrating responsive behaviours. Clinical documentation confirmed there were no assessments completed for behaviours being exhibited.
The staff person responsible for coordinating the responsive behaviour program in the home and organizing behavioural assessments confirmed she was unaware that the resident was demonstrating these behaviours. She also confirmed that the care plan did not contain directions for staff in the management of these behaviours and an assessment was not completed.
(PLEASE NOTE: This evidence of non-compliance related to not identifying behavioural triggers was found during Inspection #2014_275536_0002 / H-000859-13, H-000918-13) [s. 26. (3) 5.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 005

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that 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 that they are complied with, in relation to the following: [8(1)(b)

a)Staff in the home did not comply with the directions contained in the [Resident Death] policy identified as #NURS-02-03-06 and dated December 2002.
-This policy directed that staff were to ensure that the required forms were to be accurately and timely completed. Staff did not comply with this policy when forms required by the Coroner did not indicate that the death of resident #003 was a sudden unexpected death.
b)Staff in the home did not comply with the directions contained in the [Pronouncing Resident Death] policy identified as #NURS-02-03-07 and dated December 2002.
-This policy directed that under no circumstances may a Registered Nurses (RN) or Registered Practical Nurses (RPN) pronounce a death when the death is unexpected or one or more of the required criteria have not been met. Staff did not comply with this policy when on an identified date an RPN assessed resident #003 who was found lying on the floor as having no pulse, respiration or blood pressure and contacted the resident's power of attorney (POA) informing the POA of the death of the resident. Staff and clinical documentation confirmed that this resident was independent in many activities of daily living, did not have a medical diagnosis that would indicate the resident was actively dying and the goal of care for this resident was not identified palliative care. Staff providing care to the resident confirmed that they did not expect this resident to die.
c) Staff in the home did not comply with the directions contained in the [Responsive Behaviours] policy identified as #09-05-01 and dated September 2010.
This policy directed that staff were to report, record and investigate all new incidents of behaviours that are not currently identified in the resident's plan of care. Staff did not comply with this policy when:
-Clinical documentation confirmed that resident #007 demonstrated two responsive behaviours; however, there was no evidence in the clinical record that these behaviours were investigated or assessed.
-Clinical documentation confirmed that resident #004 demonstrated three responsive behaviours; however, there was no evidence in the clinical record that these behaviours were investigated or assessed.
This policy directed that for residents demonstrating responsive behaviours a resident focused care plan will be developed and maintained that included: triggers for the behaviour and resident specific interventions to address behaviours. Staff did not comply with this policy when:
-Clinical documentation confirmed that resident #007 demonstrated two responsive behaviours; however triggers for these behaviours where not identified and there were

no resident specific interventions developed to manage these behaviours.
-Clinical documentation confirmed that resident #004 demonstrated three responsive behaviours; however triggers for these behaviours were not identified and there were no resident specific interventions developed to manage these behaviours
This policy directed that when staff were reporting on observed behaviour they were to use the Responsive Behaviour Record or the Dementia Observation Scale to record behavioural observations. Staff did not comply with this policy when it was confirmed that neither of these records were used to record behaviours being demonstrated by resident #007 and resident #004.
(PLEASE NOTE: Evidence specific to resident #004 relating to the home not complying with the directions contained in their policy [Responsive Behaviours] was found during Inspection # 2014_275536_0002/H-000859-13, H000918-13) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that where the Act or this Regulation requires the licensee of the long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that they are complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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

Findings/Faits saillants :

1. The licensee did not ensure a written record of the evaluation of the program to management responsive behaviours was kept and that the record included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date those changes were implemented, in relation to the following: [53(3) (c)]
The Executive Director and records provided by the home confirmed that an annual evaluation of the program was completed on September 29, 2013 and the written record of that evaluation did not include the names of the persons who participated in the evaluation, a summary of changes made or the date changes were implemented. [s. 53. (3) (c)]

2. The licensee did not ensure that, for each resident demonstrating responsive behaviours, that behavioural triggers were identified, where possible, in relation to the following: 53(4)(a)
a)There were no attempts to identify behavioural triggers for resident #007 when

clinical documentation indicated that this resident demonstrated three responsive behaviours. Documentation also indicated that over a three month period of time in 2013 these behaviours increased and escalated. No assessments were found in the resident's clinical record that would have assisted the staff in attempting to establish behavioural triggers and the registered staff person responsible for coordinating the responsive behaviour program in the home confirmed that an assessment for this resident was not completed and possible triggers for these behaviours had not been identified.

b) There were no attempts to identify behavioural triggers for resident #004 when clinical documentation indicated that this resident demonstrated three responsive behaviours. Documentation also indicated that over a four month period of time in 2013 these behaviours increased and escalated. No assessments were found in the resident's clinical record that would have assisted the staff in attempting to establish behavioural triggers and the registered staff person responsible for coordinating the responsive behaviour program in the home confirmed that an assessment for this resident was not completed and possible triggers for these behaviours had not been identified.
(PLEASE NOTE: This evidence of non-compliance related to not identifying behavioural triggers was found during Inspection #2014_275536_0002 / H-000859-13, H-000918-13) [s. 53. (4) (a)]

3. The licensee did not ensure that, for each resident demonstrating responsive behaviours, that strategies were developed and implemented to respond to these behaviours, where possible, in relation to the following: [53(4)(b)]
a)Strategies where not developed or implemented to respond to three responsive behaviours being demonstrated by resident #007. Clinical documentation indicated this resident demonstrated these behaviours and that over a three month period the behaviours had deteriorated. After reviewing the care plan for this resident the registered staff person responsible for managing the responsive behaviour program in the home confirmed that strategies for the management of these behaviours had not developed.

b) Strategies where not developed or implement to respond to three responsive behaviours being demonstrated by resident #004. Clinical documentation indicated this resident demonstrated these behaviours and that over a three month period the behaviours had deteriorated. After reviewing the care plan for this resident the registered staff person responsible for managing the responsive behaviour program in the home confirmed that strategies for the management of these behaviours had not

been developed.
(PLEASE NOTE: This evidence of non-compliance related to not identifying behavioural triggers was found during Inspection #2014_275536_0002 / H-000859-13, H-000918-13) [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that for each resident demonstrating responsive behaviours that behavioural triggers are identified, where possible and behavioural strategies are developed and implemented to respond to those strategies., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee did not ensure that agency staff received training prior to performing their responsibilities in relation to the following: [76 (2)]
The Director of Care confirmed at the time of the inspection that she was unable to provide documentation that verified agency staff had been trained and orientated prior to performing their responsibilities. [s. 76. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee did not ensure the Director was immediately notified of an unexpected death, including a death resulting in an accident or suicide, in relation to the following: [107(1) 2]
Staff in the home did not notify the Director of the unexpected death of resident #003. On an identified date the resident was found lying on the floor in their room. Registered staff assessed the resident and found that the resident had no respiration, blood pressure or pulse and notified the resident's POA of the death. Documentation in the resident's plan of care indicated that the resident was independent in changing position, ate independently, required no assistance for locomotion, was independent with personal hygiene, transferred independently, used the bathroom with cuing, wore pull-up briefs to manage frequent incontinence and the goal was to maintain independence in toileting. Staff confirmed that the resident's care focus was not palliative and they did not expect this resident to die. [s. 107. (1) 2.]

Issued on this 10 day of July 2014 (A2)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129) - (A2)

Inspection No. / No de l'inspection : 2014_205129_0001 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000888-13,H-000561-13 (A2)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jul 10, 2014;(A2)

Licensee / Titulaire de permis : HALTON HEALTHCARE LTC INC.
327 REYNOLDS STREET, OAKVILLE, ON, L6J-3L7

LTC Home / Foyer de SLD : WYNDHAM MANOR LONG TERM CARE CENTRE
291 REYNOLDS STREET, OAKVILLE, ON, L6J-3L5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Stephanie Zajczenko-Opdam

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Order / Ordre :

The Licensee shall prepare, submit, and implement a plan to ensure staff provide care to all residents as set out in the plan of care. The plan shall include, but not limited to:
- A mechanism to ensure that staff are made aware of the care specified in the care plans for residents under their care.
- A schedule of ongoing monitoring of staff in the provision of care to the residents and ensuring that care identified in the care plan is provided.
The plan is to be submitted on or before March 20, 2014 by mail to Phyllis Hiltz-Bontje at 119 King St, West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by email at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified non compliant as a VPC on September 12, 2012 and on October 10, 2012 as a VPC.
2. A resident sustained two injuries when a PSW did not provide care as set out in the resident's plan of care.
3. Care as specified in the plan of care was not provided to resident #007 on an identified date in 2013 which resulted in an altercation between the resident and a care provider during which the resident received two injuries. Care specified in the plan indicated that the resident prefered to get up between seven and eight in the morning, the resident refused to have incontinent products changed at night, staff were to provide assistance when the resident insisted on being independent with activities and staff are to provide flexibility in activities of daily living routines to accommodate the resident's moods. The staff person providing care on the identified date confirmed that she got the resident up at 0530hrs for morning care because that is the staff's routine, the resident walked to the washroom where the resident swatted the staff persons hand away when she began to take off the incontinent product, the resident then pulled down the incontinent product and sat on the toilet, the staff person then began to remove the incontinent product from around the resident's ankles when the resident grabbed the staff person's hair. The resident received the injuries when the staff person attempted to release the resident's hold on her hair. This staff person confirmed that she did not provide care as was directed in the plan of care, was aware the resident could be resistive, but was unaware of the directions in the care plan related to the time the resident gets up, the requirement to be flexible in scheduling care related to the resident's mood, that the resident refuses to have incontinent products changed at night and that the resident prefers to perform tasks themself and staff are to support this approach. (129)

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

Apr 30, 2014(A2)

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

Ministère 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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A2)
The licensee shall prepare, submit and implement a plan to ensure that all residents are reassessed and the plan of care is reviewed and revised when care needs change. The plan shall include, but not limited to:
-A schedule of staff training related to what constitutes a change in care needs and how to recognize when a resident s care needs have changed.
-The development and implementation of a protocol that staff must follow when care needs have changed.
-A mechanism and schedule of ongoing monitoring that staff are compliant with the established protocol
The plan is to be submitted on or before March 20, 2014 by mail to Phyllis Hiltz-Bontje at 119 King Street, West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by email at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified non compliant as a VPC on September 12, 2012 and on October 10, 2012 as a VPC.
2. Two of two residents reviewed were not reassessed and the plans of care were

not reviewed and revised when clinical records indicated there were changing needs in regards to responsive behaviours.
3. Resident # 007 was not reassessed and the care plan was not reviewed or revised when documentation indicated the resident began demonstrating an increase in responsive behaviours.
-Data collected on the Minimum Data Set (MDS) review completed on March 28, 2013 indicated the resident demonstrated no responsive behaviours.
-Data collected on the following MDS review completed on June 19, 2013 indicated that responsive behaviours being demonstrated had increased and the resident was now demonstrated three responsive behaviours one to three days in seven days. The care plan in place at this time did not include care directions for staff in relation to the management of two of the behaviours identified as being demonstrated by the resident and staff documented that there had been no change in the behaviours being demonstrated.
-Data collected on the following MDS completed on September 11, 2013 indicated the responsive behaviours had increased and escalated and the resident was now demonstrating an additional responsive on four to six out of seven days. There had been no changes made to the care plan following this review and staff documented that the behaviours had not changed.
-The Executive Director and the staff person responsible for coordinating the responsive behaviour program in the home confirmed, the data collected would indicate that the resident's care needs had changed over the identified period of time and that staff had not reassessed the resident and did not review and revise the plan of care to reflect this change in care needs.
4. Resident #004's care needs changed, however, the resident was not reassessed and the plan of care was not reviewed and revised.
-Data collected on the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) review completed August 18, 2013 indicated that the resident demonstrated one responsive behaviour.
-Data collected on the following MDS review dated November 10, 2013 indicated that resident's behavioural symptoms were worsening. The previously identified responsive behaviour was now being demonstrated four to six days out of seven days and three new responsive behaviours were being demonstrated. The Resident Assessment Protocol (RAP) completed following this MDS review did not indicate that there was a change in behaviour and the resident was not reassessed in relation to changing behaviours. The care plan developed for this resident following the above noted MDS was not reviewed or revised and did not contain information that this resident was exhibiting any behaviours.

(PLEASE NOTE: This evidence of non-compliance related to reassessment and revision of care plan were found during Inspection #2014_275536_0002 / H-000859-13, H-000918-13) (129)

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

Apr 30, 2014(A2)

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2013_027192_0003, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that staff who had reasonable grounds to suspect that abuse of a resident had occurred or who observed a situation of resident abuse shall immediately reports the suspicion and the information on which it is based to the Director.

Grounds / Motifs :

(A1)
1. Previously identified non-compliant as a VPC on June 20, 2011 and a CO on March 1, 2013
2. A Personal Support Worker (PSW) submitted a letter to the Director of Care on an identified date indicating that on two occasions an identified co-worker verbally and physically hurt resident #009. The first incident identified in this letter indicated the identified co-worker hit resident #009 and spoke inappropriately to the resident. The second incident involved the same co-worker forcing the same resident to receive care even though the resident was resisting the care. The Director of Care documented that the staff person accused of this abuse was suspended pending an investigation; however, did not immediately notify the Director of this incident. The Director was notified the following day when a telephone call was placed to the Hamilton Services Area Office.
(PLEASE NOTE: This evidence of non-compliance related to the failure to immediately report a suspicion of resident abuse to the Director was found during Inspection #2014_205129_0002 H-000859-13, H-000918-13) (129)

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

Apr 30, 2014(A2)

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

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,

(a) procedures are developed and implemented to ensure that,

(i) residents' linens are changed at least once a week and more often as needed,

(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,

(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and

(iv) there is a process to report and locate residents' lost clothing and personal items;

(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;

(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and

(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Order / Ordre :

The licensee will put in place a process that will ensure a sufficient supply of clean face cloths and bath towels are always available in the home for use by the residents and staff providing care to residents.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Grounds / Motifs :

1. Previously identified non compliant as a VPC on August 27, 2010 and on June 21, 2011 as a VPC
2. Direct care staff confirmed that there were not sufficient clean towels available in the home to meet the care requirements of the residents. Sixteen resident's rooms were monitored on four resident home areas and no towels were noted in ten of those rooms. Linen carts on the resident home areas did not have towels available. The housekeeping manager confirmed that there have been several complaints from care staff related to the availability of towels for resident care and the linen carts prepared in the laundry area for transportation to the home areas were not stocked with a sufficient quantity of towels to meet the care needs of residents. (129)

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

Apr 30, 2014(A2)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

(A2)
The licensee shall prepare, submit and implement a plan to ensure that the plans of care for all residents demonstrating responsive behaviours are based on an interdisciplinary assessments of mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. The plan is to include, but not limited to:
-A schedule of staff training related to the identification of responsive behaviours.
-A protocol for reporting responsive behaviours and alerting members of the interdisciplinary team that a behavioural assessment is required
-A method to ensure the outcomes of the completed assessments is used to develop the plan of care.
-A method and schedule for monitoring that those assessments have been completed and that the plan of care reflects the care to be provided to residents based on the outcome of the assessment.
The plan is to be submitted on or before March 20, 2014 by mail to Phyllis Hiltz-Bontje at 119 King Street, West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by email at Phyllis.Hiltzbontje@Ontario.ca

Grounds / Motifs :

1. Previously identified non compliant as a VPC [26(3) 9] September 15, 21010 and as a VPC on September 13, 2012.
2. Two of two residents reviewed who demonstrated responsive behaviours, did not have plans of care in place that were based on an interdisciplinary assessment of those behaviours
3.The plan of care for resident #007 was not based on an interdisciplinary assessment of behaviour patterns. Clinical documentation indicated that this resident demonstrated five responsive behaviours; however, these behaviours were not assessed by the interdisciplinary team. The staff person responsible for the coordination of the responsive behaviour program in the home confirmed that behavioural assessments for resident #007 were not completed and she was unaware that the resident was demonstrating these behaviours. This staff person indicated that she reviews the progress notes written to determine those residents who are demonstrating responsive behaviours and then would coordinate with staff to ensure assessments are completed. It was confirmed that because progress notes for this resident were not identified as behavioural notes, she was not alerted

to the need to coordinate an assessment of behaviours for this resident. There was no evidence in the clinical record that an assessment of behaviours had been completed.
4. Resident #004's plan of care was not based on an interdisciplinary assessment in relation to: mood and behaviour patterns, including responsive behaviours, any potential behaviour triggers and variations in residents functioning at different times of day. The clinical record indicated that the resident demonstrated five responsive behaviours.
Registered Staff and the staff person responsible for coordinating the responsive behaviour program in the home were unaware that the resident was demonstrating these behaviours or the need to complete an assessment. PSW staff would communicate with each other each shift and then would document any behaviours on the care flow sheets. A review of the care flow sheets indicated registered staff had not signed 117 out of 168 shifts over a two month period to confirm they were aware that this resident was demonstrating these behaviours.
The staff person responsible for coordinating the responsive behaviour program in the home and organizing behavioural assessments confirmed she was unaware that the resident was demonstrating these behaviours. She also confirmed that the care plan did not contain directions for staff in the management of these behaviours and an assessment was not completed.

(PLEASE NOTE: This evidence of non-compliance related to not identifying behavioural triggers was found during Inspection #2014_275536_0002 / H-000859-13, H-000918-13) (129)

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

Apr 30, 2014(A2)

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 10 day of July 2014 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE - (A2)

Service Area Office /
Bureau régional de services : Hamilton