Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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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
May 26, 2017	2017_322156_0009	007105-17	Resident Quality Inspection

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave HAMILTON ON L9C 7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue HAMILTON ON L9C 7W9

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

CAROL POLCZ (156), CYNTHIA DITOMASSO (528), LEAH CURLE (585), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 25, 26, 27, 28, May 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 2017

The following inspections were conducted simultaneously with the RQI inspection:

Follow up 32339-16 related to prevention of abuse
Follow up 32341-16 related to transferring and positioning
Follow up 32342-16 related to training
CIS 30674-16 related to prevention of abuse
CIS 34363-16 related to prevention of abuse
CIS 7495-17 related to prevention of abuse
CIS 35194-16 related to prevention of abuse
CIS 1013-17 related to prevention of abuse
Inquiry 30677-16 related to resident refusal
Inquiry 5327-17 related to late reporting
Inquiry 5058-17 related to late reporting

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Director of Resident Services, Resident Care Supervisors, Food Services Supervisor, Occupational Therapist, Recreational Supervisor, registered nursing staff, dietary aides, personal support worker (PSW) staff, residents and families.

During the course of the inspection, the inspectors toured the home, observed meal service, medication administration, medication storage areas, recreation activities, reviewed relevant clinical records, reviewed relevant policies and procedures, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home etc.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **12 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_275536_0015	528
O.Reg 79/10 s. 36.	CO #002	2016_275536_0015	528
LTCHA, 2007 S.O. 2007, c.8 s. 76. (7)	CO #003	2016_275536_0015	528

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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

On an identified date in January, 2017, an altercation occurred between resident #071 and #072 resulting in resident #072 sustaining an injury.

i. Review of the plan of care for both residents identified that they were cognitively impaired. Resident #071 had an increase in responsive behaviours since November 2016.
ii. Progress notes for resident #071 specified that certain co-residents triggered the resident's behaviours and in the week prior to the altercation there were documented incidents of resident #071 demonstrating responsive behaviours.
iii. Interview with RPN #123 confirmed that resident #072 was not easily redirected so they implemented an intervention which was reported as an effective strategy to closely monitor the resident.
iv. During the RPN's medication administration rounds, a PSW provided care to resident #072 and instead of bringing the resident back to the RPN, resident #072 was placed in an identified area. Interview with PSW #130 confirmed that resident #072 was placed in the identified area and that resident #071 was in eye sight of resident #072 and the residents were not supervised at the time.
iv. Interview with PSW #130, #131 and RPN #123 all confirmed that the staff were aware that resident #071 would demonstrate responsive behaviours in specified situations.

Noting the residents' history of responsive behaviours prior to the altercation, the staff did not ensure steps were taken to minimize the risk of altercation between resident #071 and resident #072, resulting in an altercation and injury to resident #072. [s. 54. (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. 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).

Findings/Faits saillants :

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

A) On an identified day in December 2016, resident #073 was provided care by PSW #121. The plan of care for resident #073 identified that the resident required assistance of two staff for the specified care. Review of the home's investigation notes, interviews with PSW #121 and the Director of Resident Care Services confirmed that the resident was provided the assistance of one staff on the identified day. The plan of care was not provided to the resident as specified in the plan, related to the assistance required for the provision of specified care.

B) A review of resident #010's plan of care, including the care plan and dietary kardex indicated specific dietary food instructions. The resident was observed during meal time and was not provided with the specific dietary foods as instructed. Dietary aide #114 confirmed the care set out in the plan of care was not provided as specified in the plan.

C) In May, 2017, RPN #124 attempted to administer medication to resident #078. The resident refused to take the medication as provided. Review of the plan of care identified that the resident required medications to be provided in a specific manner, which was also outlined on the medication administration record (MAR). Interview with RPN #124 confirmed that they had missed the direction when they initially dispensed the medication for resident #078. RPN #124 did not administer medications according to the resident's plan of care.

D) i) During observation, resident #014 was noted to be distressed. The resident repeatedly stated they had no lunch and were hungry. A review of resident #014's plan of care identified the resident was at high nutritional risk. According to the plan of care, on identified dates, the staff were to save the resident's lunch and it would be provided when the resident was available. The plan of care further indicated that the resident was to be provided specialty food items at meals, as requested by the resident.
Interview with PSW #107, on the day of the observation, reported the home's dietary staff

had forgotten to place the resident's lunch aside from the daily lunch menu. PSW #107 reported that on realizing that there had been no lunch plated and saved from the regularly scheduled lunch menu, the home's staff prepared an alternate meal for the resident. PSW #107 confirmed that resident #014 became upset with the offer of the alternate meal and stated they did not want it. PSW #107 confirmed the resident was not offered another meal choice and was unaware of what the specialty foods were, that had been identified on the resident's plan of care. RPN #102 confirmed the resident's care was not provided to the resident as specified in the plan of care when their lunch meal, or specialty foods were not saved or offered to them.
ii) The dietary serving notes in the servery of the home area and the plan of care for resident #014 indicated that the resident was to receive an identified adaptive feeding aid and to receive specified menu items at lunch and supper. During the observed lunch meal, the resident was not provided with the identified adaptive feeding aid or the specified menu items as confirmed with staff #136.
iii) The plan of care for resident #014 indicated that the resident was on an identified dietary restriction. PSW staff #136 reported that they did not do anything special for the restriction and there were no directions related to the restriction. The resident was assessed by the Registered Dietitian in April, 2017 and it was noted that the resident was not following the restriction; however, the resident continued to exceed the restriction following the assessment for 11 out of 17 days. The care set out in the plan of care related to the restriction was not provided to the resident as specified in the plan.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Under s. 30(1)1. relevant policies, procedures and protocols are required in relation to programs required in relation to section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation. Regulation r. 52 requires the licensee to establish a pain management program and r. 48. (1) requires the licensee to establish a falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy Pain Assessment and Documentation, policy 8-1 Pain Management Program revised May 8, 2017 indicated that when pain has been identified prompt and appropriate interventions will be implemented and evaluated for effectiveness. Pain assessments are to include both subjective and objective data. With PRN (as needed) medication administration documentation and follow up must occur as per the timelines on the Analgesic Usage and Evaluation Flowsheet and PRN usage form.

Progress notes for resident #005 identified that the resident was experiencing pain on two identified dates in November, 2016, two identified dates in January, 2017, as well as two identified dates in February, 2017, however, pain assessments were not completed as confirmed with registered staff #128.

B) The home's policy, Falls Prevention and Post Fall Management Program - Number 9 - 1, revised February 2017, outlined the procedure for a resident fall event, "if the fall was unwitnessed, or a resident has hit their head, a head injury routine (HIR)/neuro-vital

assessment will be initiated. Please see Head injury routine policy." The home's policy, "Head Injury Routine - Number: 9-2", revised February 2017, stated Head Injury Routine (HIR) is started with half hour assessments for 2 hours, every 1 hour for 4 hours and every 4 hours for 24 hours, unless ordered by the physician. The following shall be assessed: level of consciousness, pulse, respiration, blood pressure, pupillary reaction, motor response, response to painful stimuli. The above procedures to be completed and documented by Registered staff on the Neurological Assessment Record (Appendix A). Document assessment of each HIR assessment each shift in the progress notes until HIR is completed.

Review of resident #011's clinical record revealed they were at high risk for falls.
i) On an identified date in April, 2017, progress notes completed by registered staff #134 documented that resident #011 experienced an unwitnessed fall. The resident sustained an injury and the Neurological Assessment Record was initiated.
ii) On another identified date in April, 2017, resident #011 experienced an unwitnessed fall. The Neurological Assessment Record was initiated.
Review of documentation for both falls revealed the Neurological Assessment Record was not completed at all required times as specified in the record. Registered staff #135 confirmed the Neurological Assessment Record was not completed as required on five occasions, and stated the times to which it was not completed were busy times for registered staff, which made it difficult to ensure the record was completed.
Interview with the DOC confirmed the Neurological Assessment Record was to be completed when the resident experienced an unwitnessed fall. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Review of the clinical record for resident #005 indicated that two bed rails were discontinued in November, 2016; it was not clear why the bedrails were discontinued. During the inspection; however, one bed rail was observed in the up position for the bed of resident #005. Interview with the PSW staff #122 on May 9, 2017, confirmed that the resident used the one bed rail and the DOC confirmed that an assessment was not completed. [s. 15. (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 where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

The home's policy Non Abuse of Residents, revised April 2014, stated that "every staff member in all disciplines and at all levels have an obligation and a duty to immediately report any act of resident abuse such as physical abuse, emotional abuse, financial abuse, neglect, sexual abuse or verbal abuse".

A) On two unidentified days in February 2017, PSW #117 alleged PSW #116 made inappropriate comments about a resident and said verbally abusive comments to two residents. PSW #117 approached the RN on duty and reported that they had a "concern"; however, due to workload, the conversation was postponed. PSW #117 then was scheduled off for an unidentified number of days, at which time, resident #070 reported a separate allegation of verbal abuse by PSW #116. Review of the home's investigation notes, confirmed that abuse was not substantiated. Interview with PSW #117 and the Director of Resident Services confirmed that PSW #117 did not report witnessed verbal abuse immediately as required in the home's policy.
B) On an identified day in October 2016, staff #118 reported allegations of rough handling of a resident by PSW #119. Review of the homes investigation notes identified that the home was not aware of the allegations until the day after the incident. Interview with staff #118 confirmed that the allegations were not reported immediately, as required in the home's policy. Instead, they waited until their manager was present the following day. When they notified their Manager, they were instructed to report the incident to the RN. Interview with the Director of Resident Services confirmed that staff #118 and their Manager should have reported the allegations immediately, and the home's policy was not complied with. [s. 20. (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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with, to be implemented voluntarily.

WN #6: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident safety risks.

Observation of resident #005 and #090's bed systems identified they each had a mattress on their bed with raised sides.
Interview with the DOC on May 16, 2017, verified that both residents had a mattress with raised sides, indicated that the home referred to these surfaces as bolster mattresses.
Review of the home's records revealed the home had approximately 12% of these mattresses in the home.
Review of the plans of care did not include an assessment of the residents with respect to the use of the bolster mattresses, nor did it identify if the surface supported the residents with an activity of daily living, restricted their movement out of bed or any other safety risks associated with the use of the device.
The use of the bolster mattress was not included in either of the resident's plan of care.
Interview with the DOC verified that the home did not assess residents for the use of bolster mattresses in relation to safety risks. The plans of care were not based on an assessment of the residents safety risks. [s. 26. (3) 19.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident safety risks, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #009 had altered skin integrity as noted on the initial assessment in April, 2017. Three days later, progress notes indicated that the area was not re-assessed by a member of the registered nursing staff. The next assessment was completed by the wound care team in May, 2017. Weekly wound assessments were not completed for two identified dates in April, 2017 as confirmed with the DOC.

B) Resident #005 had altered skin integrity as noted in the progress notes in November, 2016. Weekly skin assessments were not completed by a member of the registered nursing staff for two identified dates in January, three identified dates in February, three identified dates in March, and two identified dates in April, 2017 as confirmed with registered staff #128. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Review of resident #001's plan of care identified they were incontinent and staff were to provide care to the resident before and after meals, every night and as needed, initiated March, 2016. The plan stated they also required one person assistance for toilet use for safety due to multiple falls; may require two staff mood depending, revised February, 2017. An annual bowel and bladder continence assessment, completed February, 2017, identified they were motivated to be continent, required assistance for toileting and assistance for transferring.

i) In May, 2017, resident #011 was observed entering their room and the resident was observed in the washroom with no staff present. Interview with PSW #125 reported the resident toileted independently, should use a call bell but confirmed the resident did not use their call bell when they required assistance. PSW #125 reported staff check to assist the resident after meals; however, they had not reached the resident's room yet. The resident was observed seated in a chair in their room. The resident was exposed and PSW #125 assisted the resident with adjusting their clothes.
ii) In May, 2017, resident #011 was observed sitting in the washroom with no staff present. PSW #125 reported again that the health care staff had not reached the resident's room yet to provide care. The resident was out of their washroom when the PSW went into the resident's room to provide care. Interview with PSW #133 also reported the resident would toilet independently and did not ring the call bell reported that the resident required extensive assistance with toileting. RPN #124 reported the resident did not use the call bell and required assistance.
The licensee failed to ensure that resident #011 who was unable to toilet independently some or all of the time, received assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who was unable to toilet independently some of all of the time received assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the pain management program must, at a minimum, provide for monitoring of residents' responses to, and the effectiveness of, the pain management strategies.
Resident #005 was administered PRN pain medication on two identified dates in February, 2017, however, no follow up evaluation of the PRN medication was documented as confirmed with registered staff #128. [s. 52. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the pain management program must, at a minimum, provide for monitoring of residents' responses to, and the effectiveness of, the pain management strategies, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) In December 2016, resident #071 was noted to have responsive behaviours. As a result, Demenita Observation System (DOS) that included observation of the resident every 30 minutes was initiated to observe the resident's behavioural patterns. Review of the DOS charting for the week did not include documentation of the resident's behaviours every 30 minutes as follows:
In December, 2016, when the monitoring was initiated, there was no documentation of the resident's behaviours on the DOS assessment.
On four subsequent dates in December, 2016, during four separate time frames, there was no documentation on the DOS assessment; furthermore, the progress notes documented two incidents of verbal behaviours on one of the evenings.
Interview with RPN #123 and the DOC confirmed that the residents behaviours were not documented on the DOS charting assessment form.

B) The plan of care for resident #074 identified that the resident had behavious resulting in physical altercations with co-residents.
i) On an identified date in March, 2017, resident #074 had a physical altercation with another resident, no injuries were noted. Review of the progress notes identified that interventions were implemented. Interview with RPN #123 confirmed that registered staff documented the interventions would be implemented but had not been completed.
ii) A second physical incident occurred with co-resident #075 over two weeks later. A monthly Risk Management note identified that recreation had set up an identified intervention for resident #074, which had been effective. Throughout the course of the inspection, the identified intervention was not found in the resident's home area.
Interview with PSW #127 and Recreation therapy staff #129 confirmed that the intervention had not been set up on the unit for resident #074 to use.
Actions were not taken when resident #074 had displayed physical behaviours, as outlined in the resident's plan of care. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

A) In May, 2017, resident #004 was observed in a wheelchair, with a restraining device that was not applied according to manufacturer's instructions.
The plan of care identified the device was to be checked hourly and the device was to be released and the resident repositioned every two hours.

Interview with RPN #104, confirmed the resident was at risk for sliding from their chair and that the device and chair were a PASD with restraining properties.
Interview with the Occupational Therapist confirmed the specified devices, were to be applied in a specified manor. Interview with the Director of Resident Services confirmed the device, had not been applied in accordance with any manufacturer's instructions.

B) Resident #040 was observed to be in a wheelchair with a specified device. The device was observed to be not applied according to manufacturer instructions. The resident was required to be checked every hour for safety and comfort and to be released and repositioned every two hours. Interview with RPN #108 confirmed that the resident's device was not applied as per the manufacturer instructions. The RPN stated the device was used as a PASD and had restraining properties. [s. 110. (1) 1.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: 7. Every release of the device and all repositioning.

A) A review of resident #004's clinical record described the use of a specified device as a PASD that had restraining properties. PSW #103 and RPN #104 stated resident #004 was checked every hour and repositioned every two hours and at other times as required. PSW #103 stated that they documented the release and repositioning in the resident's POC documentation once a shift.
A review of the Point Of Care (POC) documentation, for resident #004, confirmed the staff documented the release of the device and all repositioning only once every shift. Interview with the Director of Resident Services (DRS) confirmed the documentation direction to front line staff had changed to documenting only once per shift under a generalized summary question in POC that stated "During the shift the device was removed and the resident repositioned every two hours". The DRS confirmed the home's previous documentation required every release and repositioning of the resident to be documented on a restraint flow sheet. A review of the home's Resident Care Manual; Restraint use at St Peter's Residence, review date July 2016, indicated a restraint flow sheet will be used and documentation will include every release of the device and repositioning of the resident.

B) A review of resident #040's clinical record described the use of a specified device as a PASD that had restraining properties. RPN #108 stated resident #040 was checked every hour and repositioned every two hours and at other times as required. PSW #103

stated that they documented the release and repositioning of the resident's POC documentation once a shift.
A review of the Point Of Care (POC) documentation, for resident #040, confirmed the staff documented the release of the device and all repositioning only once every shift. Interview with the Director of Resident Services (DRS) confirmed the documentation direction to front line staff had changed to documenting only once per shift under a generalized summary question in POC that stated "During the shift the device was removed and the resident repositioned every two hours". The DRS confirmed the home's previous documentation required the documentation of every release and repositioning of the resident to be documented on a restraint flow sheet. A review of the home's Resident Care Manual; Restraint use at St Peter's Residence, review date July 2016, indicated a restraint flow sheet will be used and documentation will include every release of the device and repositioning of the resident. [s. 110. (7) 7.]

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 following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation; (c) that the results of the analysis undertaken under clause (a) are considered in the evaluation; (d) that the changes or improvements under clause (b) are promptly implemented.

Two residents were observed with devices that were not applied according to manufacturers instructions. On review of the these residents plan of care, they had been identified at risk of sliding in their wheelchairs. Two registered staff interviewed confirmed they recognized the risk that the resident could slide down in the chair and that the device that had not been applied according to the manufacturers instructions posed a risk. Two registered staff and one PSW identified that they were not permitted or trained

to immediately adjust the device and that the resident may have to wait depending on the availability of the Occupational Therapist (OT) to assess and adjust the resident's device. The following was the process described to be followed by the front line staff when a broken, loose or improper fitting device was identified:
1. PSW would notify the registered staff
2. Registered staff would notify the OT
3. OT would come and assess and adjust/fix the device

Interview with the home's Occupational Therapist confirmed the above process further stating the direction for the front line staff was that they were not to adjust or readjust the specified device. The OT confirmed that they would get a referral to look at non fitting or broken devices and follow up on the days that they were assigned to work in the home. The OT confirmed they triaged their daily work load based on resident risk. The OT stated the resident would be returned to their bed, for safety, until they were able to adjust the devices. The OT confirmed they did not work weekends or evenings and had recently, in the previous week, been away from the home for two of their scheduled five days. The OT stated the responsibility for the specified devices were also assigned to the Physiotherapist (PT) and two physiotherapy assistants (PTAs) and that they had been trained and permitted to adjust/alter resident devices. It was confirmed by the Director of Resident Services that the OT and PTAs did not work weekends or evening/nights.
The DRC confirmed that the licensee's practice for the home was for only the OT and PT to adjust or readjust the devices and that the front line staff would not adjust the devices but would make a referral to the OT or PT. The Director of Resident Services (DRC) confirmed that the absence of trained or assigned staff to provide assessment and adjustments of the specified devices, that had restraining properties, over the weekends and evening/nights had been identified as a necessary change in the home's previous 2016 annual evaluation.
The DRC confirmed that the home's 2016 restraint evaluation was completed, to determine the effectiveness of the licensee's policy under section 29 of the Act, and that changes and improvements were identified. The DRC stated the home's intent from the analysis was to change this practice as it left the residents without immediate access to a safety assessment/adjustment of their specified devices if the OT, PT or PTAs were not in the home. The DRC stated new training was to be put in place to train front line registered staff on assessing and adjusting devices.
Interview with the registered staff lead for the Safe Client Handling committee confirmed the restraints committee completed an annual evaluation in 2016 and that the home was working on getting the committee up and running again in 2017. Both the DRC and the lead from the Safe Client handling committee confirmed that no actions had been taken

to educate or assign the front line staff the responsibility for assessing or adjusting the devices, that had restraining properties, since the 2016 evaluation.
The DRC confirmed the licensee failed to promptly implement the changes or improvements under clause (b) as described above. [s. 113. (d)]

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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation; (c) that the results of the analysis undertaken under clause (a) are considered in the evaluation; (d) that the changes or improvements under clause (b) are promptly implemented, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's Infection Prevention and Control (IPAC) Manual, included policy, Hand Hygiene – Number 3-01, reviewed June 13, 2016. The policy listed general indications for hand hygiene, which included, but was not limited to: before and after contact with a residents or items in their environment, before preparing, handling, serving or eating food.

On May 5, 2017, during meal service in an identified home area dining room, PSW #115 was observed serving residents and clearing dirty dishes and then serving foods and fluids to other residents without performing hand hygiene. Interview with Registered staff #113 confirmed the home's expectation was that staff perform hand hygiene between removing/clearing soiled dishes and then serving food to other residents. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked.

Staff washroom #028 on the main floor was observed unlocked through the course of the inspection. Interview with the DOC confirmed that residents could use the washroom although it was intended for staff only and was not kept locked. [s. 9. (1) 1. i.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and residents responses to interventions were documented.

Resident #011's plan of care related to recreation and social activities identified that they participated in programming in their room, on the unit and out of the building. Review of look-back reports in the clinical record regarding participation in recreation programs between identified dates from April to May, 2017, revealed no documentation to indicate whether the resident was invited to and/or participated in the activity programs, including 1:1 programs, group programs and community outings.
Interview with resident #011 who reported they enjoyed participating in some activity programs and staff invited them to participate. Interview with the recreation supervisor who reported the resident was invited to recreation and activity events; however, confirmed staff did not complete documentation to indicate the resident's responses to offers or acceptance to participate in recreation programs between the identified dates in April to May, 2017. [s. 30. (2)]

Issued on this 22nd day of June, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156), CYNTHIA DITOMASSO (528), LEAH CURLE (585), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2017_322156_0009
Log No. / Registre no:	007105-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 26, 2017
Licensee / Titulaire de permis :	ST. PETER'S CARE CENTRES 125 Redfern Ave, HAMILTON, ON, L9C-7W9
LTC Home / Foyer de SLD :	ST. PETER'S RESIDENCE AT CHEDOKE 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renee Guder

To ST. PETER'S CARE CENTRES, 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 :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall prepare submit and implement a plan to ensure that interventions are identified and implemented to minimize altercations between resident #071 and any other co-residents. Specifically, residents that are a trigger for aggression, including but not limited to resident #072.
The plan shall be submitted to to Cynthia.ditomasso@ontario.ca by June 15, 2017.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #072 experienced, the scope of isolated, and the Licensee's history of non-compliance (VPC) on the August 15, 2016 Resident Quality Inspection with r.54 (b) being issued.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

On an identified date in January, 2017, an altercation occurred between resident #071 and #072 resulting in resident #072 sustaining an injury.

i. Review of the plan of care for both residents identified that they were cognitively impaired. Resident #071 had an increase in responsive behavuours since November 2016.
ii. Progress notes for resident #071 specified that certain co-residents triggered the resident's behaviours and in the week prior to the altercation there were documented incidents of resident #071 demonstrating responsive behaviours.
iii. Interview with RPN #123 confirmed that resident #072 was not easily redirected so they implemented an intervention which was reported as an effective strategy to closely monitor the resident.
iv. During the RPN's medication administration rounds, a PSW provided care to resident #072 and instead of bringing the resident back to the RPN, resident #072 was placed in an identified area. Interview with PSW #130 confirmed that resident #072 was placed in the identified area and that resident #071 was in eye sight of resident #072 and the residents were not supervised at the time.
iv. Interview with PSW #130, #131 and RPN #123 all confirmed that the staff were aware that resident #071 would demonstrate responsive behaviours in specified situations.

Noting the residents' history of responsive behaviours prior to the altercation, the staff did not ensure steps were taken to minimize the risk of altercation between resident #071 and resident #072, resulting in an altercation and injury to resident #072 (528)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

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 soins 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 soins 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 26th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

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