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

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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
Aug 12, 2016	2016_168202_0013	012039-16	Resident Quality Inspection

Licensee/Titulaire de permis

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET NEWMARKET ON L3Y 2L1

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

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET NEWMARKET ON L3Y 2L1

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

VALERIE JOHNSTON (202), JENNIFER BROWN (647), MATTHEW CHIU (565), SHIHANA RUMZI (604)

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): May 18, 19, 20, 24, 25, 26, 27, 30, 31, June 01, 02, 03, 06, 07, 08, 09, 10, 13, 14, 2016.

During the course of the inspection the following Critical Incident Inspections were completed:

-Staff to resident abuse: 003523-14, 009656-14, 036266-15, 011262-15, 011280-16,

036111-15, 019810-15, 005483-16, 016426-15, 001918-15.

-Visitor to resident sexual abuse: 002520-15.

-Improper care that caused injury to a resident: 003852-14, 004988-15.

-Resident fall with injury: 001357-14, 008980-14, 004990-15, 012209-15, 009361-16.

-Resident fracture of unknown cause: 000041-15, 002908-16.

-Missing resident greater than three hours: 002464-14, 007665-14.

During the course of the inspection a follow up order was inspected related to reporting of abuse: 035282-15.

During the course of the inspection the following complaint inspections were completed:

-Neglect and lack of care to an identified resident: 007291-16.

-Resident identified with responsive behaviours affecting other residents: 030892-15.

-Confirmation that a complaint issued to the home had been forwarded to the Ministry of Health: 010778-16.

During the course of the inspection the inspector (s): reviewed clinical records, conducted a tour of the home, observed lunch meal service, reviewed home's policies related to transferring and positioning, falls prevention, skin and wound care, continence care, responsive behaviours, advanced directives, reviewed Residents' Council meeting minutes, staffing schedule, employee files.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC's), Dietary Manager (DM), Food Services Supervisor (FSS), Environmental Manager (EM), Social Worker, Human Resources Advisor (HRA), Life Enrichment Staff, Housekeeping Staff, Wound Care Champion (WCC), Registered Nurses (RNs),

Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.

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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **3 VPC(s)**
- **2 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. 24. (1)	CO #001	2015_168202_0021	202

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.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents are protected from abuse by anyone and free from neglect by the licensee or staff.

The Long Term Care Homes Act, 2007. O.Reg 79/10, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a CIS on an identified date indicating that resident #048 had been sent to hospital for further assessment as the resident's health had declined after the insertion of a medical appliance. The resident returned to the home in 14 days after receiving treatment and care of an identified injury resulting from a traumatic application of an identified appliance performed by a registered nurse on an identified shift and identified date.

A review of resident #048's clinical records revealed that on an identified date the physician had ordered an identified specimen to be collected for lab testing. The progress notes for resident #048 were reviewed for 24 hours post physician order and revealed the following:

-Time A: Resident #048 had received application of an identified medical appliance by a RN. The resident became agitated during the procedure and an identified analgesic had been given for discomfort.

-Time B: The resident complained of pain and analgesic was given and the resident's facial colouring was pale.

-Time C: Charge nurse was advised that the resident had received an identified procedure and application of an identified appliance, had discomfort and blood was present at the procedural site.

-Time D: The resident was assessed for results from the application of the identified appliance with scant blood located at the appliance site. The device was removed by charge nurse and resident was observed to have a bloody discharge for 30 minutes from the identified appliance site. Resident was sent to hospital soon after.

A review of the hospital consultation notes from resident #048's hospitalization stated that the resident had received a procedure and application of an identified medical appliance in his/her nursing home and that the appliance had been possibly placed incorrectly.

An interview with RN #160 revealed that at the beginning of his/her shift, he/she had read direction posted by the earlier shift Registered Practical Nurse (RPN) in the communication book directing him/her to complete a procedure to obtain an identified specimen for lab testing. The RN stated that at an approximate time, with the assistance of PSW #163, completed the identified procedure. The RN further stated that he/she had been unaware at the time of the procedure that a physician's order had not been obtained and had he/she known would not have conducted the procedure and the application of the identified appliance.

RN #160 indicated that during the procedure resident #048 had grabbed his/her hand and indicated that he/she was in pain. The RN further indicated that he/she recognized the resident was in pain, continued to proceed with the procedure and provided the resident with an identified analgesic to reduce his/her pain. The RN stated that he/she then requested the PSW to monitor the resident.

PSW #163 no longer an employee of the home had been identified as having assisted RN #160 with resident #048's identified procedure. Attempts had been made to contact the PSW by the inspector; however, contact could not be made. As a result, interviews were conducted with Assistant Director of Care (ADOC) #114 and the Human Resource Advisor (HRA) in order to obtain PSW #163's statement and details of the interview conducted by the home.

ADOC #114 and HRA #164 indicated that during the home's investigation PSW #163 had provided the home with a statement of events that occurred during the identified shift and date. The HRA stated that PSW #163 had confirmed assisting RN #160 with the application of the identified medical appliance, at the beginning of the identified shift. Both the HRA and ADOC #114 indicated that PSW #163 had been directed by the RN to

monitor the resident; however, the PSW had stated in his/her statement that he/she only monitored to ensure that the resident did not remove the identified appliance.

An interview with RPN #143 indicated that on the above identified date, RN #160 provided him/her with a brief report at the start of his/her shift, indicating that resident #048 had an identified medical appliance in place and that there had been no results from the placement of the appliance. The RPN further indicated that at approximately one and a half hours later, he/she went to check on the resident, noticed that the appliance was in place and that the resident remained with no results. Approximately two hours later, the RPN indicated that the resident appeared to be uncomfortable and blood had been found around the appliance site. At approximately one half hour later, the RPN and the RN in charge completed an assessment and the RPN stated that at this time, they had removed the identified appliance and the resident had been observed a bloody discharge for approximately 30 minutes. The resident was then sent to hospital for further assessment.

When asked of RN #160 whether resident #048 had been assessed at any time during the identified shift and date, the RN indicated that he/she was not able to assess the resident as much as he/she should have because the identified shift was busy. The RN stated that he/she had performed an identified procedure and application of a medical device to resident #048 at the beginning of the shift and asked PSW #163 to monitor the resident.

Interviews with the DOC and ADOC #114 indicated that upon completion of the home's investigation confirmed that resident #048 had been neglected by RN #160 during the identified shift of the above mentioned identified date, as the RN failed to complete additional assessments after the application of the medical appliance. Both the DOC and the ADOC further stated that RN #160 did not recognize that the identified medical appliance had not been successful for at least six hours and failed to act, placing resident #048's health at risk and in addition had not obtained a physician's order to apply the identified appliance.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

At the beginning of an identified shift of an identified date, RN#160 performed an identified procedure and application of an identified appliance to resident #048 without a physician's order and failed to act, assess and provide the appropriate care and

treatment post procedure. The RN confirmed that he/she failed to act and provide care to resident #048 when required and as a result the resident required hospitalization for treatment and care of the identified diagnosed injury resulting from a traumatic identified procedure.

The scope of the non-compliance is isolated to resident #048.

The home has previously been issued a Voluntary Plan of Correction (VPC), under LTCHA, 2007,. c.8, s. 19 (1), on October 15, 2016, within report #2015_168202_0021.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity are fully respected and promoted.

The home submitted a Critical Incident Report (CIS) on an identified date, that indicated during an identified season of an identified year, Personal Support Worker (PSW) #116

had recorded a video on his/her cell phone of PSW #115 lying on resident #047's bed and the resident had been seen sitting in his/her wheelchair by the bed and poking at PSW #115.

An interview with Registered Nurse (RN) #117 revealed that at an identified time in 2016, he/she became aware of a recorded cell phone video that PSW #116 had been showing to others. The RN indicated that he/she had never seen the video, however, had heard from another individual that it was of PSW #115 lying on resident #047's bed while the resident had been sitting in his/her wheelchair while in the room. The RN further indicated that he/she believed the video to have been recorded in a previous year and had been shown at a family function. . The RN stated that he/she only became aware of the video in 2016, after the family member had reported it, months after it had been exposed.

PSW #116 stated in an interview that he/she had heard there was a cell phone video of PSW #115 lying on resident #047's bed and that he/she had never used his/her phone for recording purposes and did not have the video on his/her phone.

PSW #115 revealed in an interview that during at an identified time in 2015, he/she had been in resident #047's room to provide him/her care. The PSW indicated that he/she decided to lie down on the resident's bed and pretended he/she was dying. The PSW stated that resident #047 who had been sitting in his/her wheelchair at the time began to comfort him/her and suggested that it was okay for him/her "to go". The PSW indicated resident #047 had been identified with responsive behaviors that included refusal of care and would be more accepting of care when staff joked with him/her and to make the resident laugh and it had been his/her intention at the time.

PSW #115 further revealed that PSW #116 had been in resident #047's room at the same time and he/she had observed PSW #116 using his/her cell phone. PSW #115 stated that he/she believed PSW #116 to have been using the phone to call someone and had not been aware that PSW #116 had been actually been recording a video. PSW #115 stated that he/she has never seen the video and confirmed that he/she only became aware of the cell phone video recording this year when the home began their investigation.

An interview with the Director of Care (DOC) revealed that on an identified date in 2016, RN #117 had reported the above mentioned cell phone video to her. The DOC indicated that the home immediately investigated and it had been confirmed through a written

statement from another individual that PSW #116 had shown a video of a resident sitting on his/her wheelchair with a staff member lying on the bed and stating "there is a dead person on my bed", while PSW #116 had been heard laughing in the background.

PSW #115 further indicated that during the home's investigation process realized that his/her actions had allowed resident #047 to believe that he/she was dying which was wrong and disrespectful to the resident. The DOC indicated that the home's investigation concluded that PSW #115 and PSW #116 had not treated resident #047 with dignity and respect when the resident had been videotaped, was led to believe that PSW #115 was dying and shared the video to others. The DOC confirmed that resident #047's right to be treated with dignity and respect by both PSW #115 and #116 had not been fully respected and promoted. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the right of every resident to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs had been fully respected and promoted.

The home submitted a Critical Incident Report (CIS) report on an identified date, indicating that resident #048 had been found in bed expressing discomfort. The resident was then transferred to hospital for further assessment and returned to the home on the next day, diagnosed with identified injuries of an identified area of the body. The report further indicated that the Substitute Decision Maker (SDM) for resident #048 had been upset and expressed that the resident may have been harmed by staff during a transfer. The home investigated the incident and confirmed that there was no causal incident to warrant the identified injury and that the injuries were pathological in nature.

A review of resident #048's clinical records revealed that the resident had been admitted to the home on an identified date in 2014. A review of resident #048's written plan of care directed staff to use two staff assistance for all Hoyer mechanical lift transfers, one staff to position and supervise the resident for safety and one to maneuver the Hoyer lift. The plan of care also directed staff to provide toileting assistance with two staff present, one staff to support and position the resident and one staff to complete tasks of product changes and hygiene.

Resident #048's progress notes indicated that at an identified time and date, while the resident was in bed, the resident screamed out in pain when staff attempted to assist him/her from the bed and was sent to hospital for further assessment. The resident returned to the home the following day diagnosed with two identified injuries.

All direct care staff who had worked prior to the identified injury and post identified injury, those assigned to resident #048 and those who had worked on the identified home area were interviewed. All staff interviewed did not reveal an incident or occurrence that would have caused the two identified injuries, however, revealed the following:

PSW #139 indicated that he/she provides care to resident #048 on an identified shift with another staff member as directed in the plan of care. The PSW revealed that he/she had heard reports that resident #048's SDM had transferred the resident by him/herself using the Hoyer mechanical lift, however, had not witnessed this.

PSW #140 stated that resident #048's SDM is actively involved in the resident's care and has found the resident already in bed after lunch when prompted to provide the resident with care. The PSW further stated that he/she although he/she has told the SDM not to transfer the resident; the SDM had indicated that "he/she likes to take care of resident #048".

PSW #101 revealed that he/she is the primary PSW assigned to resident #048 and is responsible for the resident's care and transfers. The PSW stated that the resident is transferred to bed after lunch every day, however, the time varies dependent upon if the SDM takes the resident off the home area for a walk or outing and whether he/she has first or second break. The PSW stated that his/her break time changes every second week, one week he/she has the earlier break and the next he/she has the later break. The PSW indicated that every second week when he/she has the later break, the SDM will transfer the resident to bed using the Hoyer lift by herself because the SDM does not like to wait. PSW #101 revealed that resident #048's SDM has transferred the resident by him/herself using the Hoyer mechanical lift from the time that the resident had been admitted.

PSW #142 indicated that he/she had been assigned to resident #048 for an identified shift. The PSW further indicated that he/she has witnessed resident #048's SDM transfer the resident to bed by him/herself using the Hoyer mechanical lift. PSW #142 revealed that resident #048's SDM will often take the resident off the home area after dinner and will transfer the resident to bed and provide his/her personal care, not wanting to wait for staff assistance. PSW #142 indicated that the SDM has been told not to transfer the resident and most notably after the resident's diagnosed injuries of the identified above mentioned date.

RPN #143 indicated that resident #048's SDM had transferred the resident using the mechanical lift many times. The RPN stated that he/she had walked into resident #048's room while the SDM was transferring the resident and had tried to stop him/her. The RPN indicated that the SDM had been told it is not safe to transfer the resident by him/herself, however, continued to do so.

RPN #104 stated that resident #048's SDM is very involved in the resident's care and had transferred the resident using the mechanical lift by him/herself. The RPN stated that at an approximate time ago, he/she had found the SDM transferring the resident by him/herself using the mechanical lift, even after the awareness of the resident's identified injuries and had been told not to.

Resident #048's progress notes were reviewed from the resident's time of admission which revealed three documented incidents of resident #048's SDM observed to transfer the resident using the mechanical lift.

An interview with resident #048's SDM revealed that he/she had been transferring and providing care to the resident using the Hoyer mechanical lift by him/herself from the time that the resident had been admitted to the home. The SDM indicated that he/she would like the resident to go to bed after meals and that he/she does not like to wait for staff and that some staff do not transfer the resident properly.

A review of the home's Safe Lifting with Care Program, Mechanical Lifts policy, #01-02 revised May 2009, states "only staff trained and competent in the use of Mechanical Lifts will perform resident transfers using this equipment. Two trained staff are required at all times when performing a Mechanical Lift".

Interviews with the DOC, ADOC #114 and ADOC #146 indicated that they only became aware that resident #048's SDM had been transferring the resident by him/herself using the Hoyer mechanical lift through the home's investigation of resident #048's identified injuries diagnosed on the above mentioned date.

ADOC #146 was further interviewed during the course of the inspection. When asked whether the home had interventions in place to ensure that the resident is transferred by staff and in accordance to the resident's assessed care needs, the ADOC indicated that the SDM has been told to not transfer the resident and that staff are to monitor for any transfers conducted by the SDM, document and report to the supervisor. When asked whether he/she was aware that the SDM had attempted to transfer the resident on an

identified recent date, the ADOC indicated that he/she only became aware of it recently.

The licensee has failed to ensure that resident #048 had been provided transferring assistance with two staff and a mechanical lift for all transfers from the time the resident had been admitted. The DOC, ADOC #114 and ADOC #146 all confirmed that resident #048's right to be cared for in a manner consistent with his/her needs had not been fully respected and promoted and as a result placed resident #048 at risk of injury.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #048 was diagnosed with identified injuries on an identified date. Interviews with direct care staff confirmed that from the time of resident #048's admission in 2014, the resident had been continually transferred by the resident's SDM from wheelchair to bed using a Hoyer mechanical lift alone. Resident #048's care needs required him/her to be transferred using a Hoyer mechanical lift with two staff present at all times. Management of the home became aware of the SDM's transferring practices during the home's investigation of the resident's identified injuries and as a result the SDM was made aware of the risks associated with him/her transferring the resident and staff were directed to document and report any further incident. Records and staff interviews indicated that the SDM attempts to continually transfer the resident and most recently the SDM had been observed by RPN #143 to be in mid transfer from wheelchair to bed. At the time of the inspection the licensee failed to provide interventions to ensure that resident #048's right to be cared for in a manner consistent with his/her needs.

The scope of the non-compliance is isolated to resident #048.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007., c.8. s. 3.: A voluntary plan of correction (VPC) was previously issued under LTCHA, 2007., c.8., s. 3 (1) 1, s. 3 (1) 3 and s. 3 (1) 9, during a Resident Quality Inspection (RQI) issued to the home on January 16, 2015, under Inspection #2015_297558_0001.

3. The licensee has failed to ensure that the resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

During stage two resident interview, resident #031 was troubled and informed the

inspector of his/her transfer which took place on an identified date and time. The resident indicated his/her transfer had been observed by four staff, which she/he did not agree upon. Resident stated he/she was upset and asked why there were four staff in his/her room and RPN #132 indicated staff had raised an issue of unsafe transfer which affected staff safety.

An interview conducted with the Environmental Manager (EM) #135 indicated he/she observed the room spacing for the transfer and suggested to resident #031 if it was possible to observe a transfer which would involve physiotherapy. The EM indicated resident #031 was not agreeable to have a transfer observed. The EM further indicated the next morning an Occupational Health and Safety (OHS) staff #136 had informed him/her that the day nurse asked him/her to be present to observe a transfer for resident #031 and resident was upset.

An interview with RPN #132 confirmed he/she asked staff to transfer resident #031 from wheelchair to bed at an identified time with four staff present in the resident's room. The RPN indicated he/she had the OHS staff #136 observing, him/herself and two PSWs #133, and PSW #134 conducting the transfer. The RPN further indicated she/he did not get consent to have a transfer observed and indicated the resident was upset. The RPN stated he/she assumed the EM had received consent from the resident.

Interviews conducted with OHS #136 and PSW #133 confirmed they were asked by RPN #132 to observe a transfer for resident #031 and assumed consent was received for staff to observe the transfer but did not hear anyone get consent at the time. Both staff indicated the resident was upset during the transfer and questioned as to why transfer was being observed.

An interview with the ADOC #114 indicated she/he was aware of the refusal for a transfer observation by resident #031 but did not know the transfer observation had occurred. ADOC #114 further stated if resident #031 did not give consent to staff to observe his/her transfer the residents' right to give consent to care was not respected by staff and indicated the home would carry out an internal investigation. [s. 3. (1) 11. ii.]

4. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On May 27, 2016, at 0845 hours, the inspector observed an unattended medication cart

to be stored outside of the dining room in front of the staff bathroom during breakfast on an identified home area. The Electronic Medication Administration Record (E-MAR) screen was left open to resident #035's personal medication administration record, which was visible to the public.

An interview with RN #119 confirmed that the E-MAR screen was unlocked and personal medication administration information was visible to anyone passing by and did not protect the resident #035's personal health information.

The home follows the Medical Pharmacy's MED-elink Chapter six – Med Pass process. On page 6-7 process 6.2 Documenting A Medication Administration On Med-eLink (Basics), process four directs staff to lock the E-MAR screen when leaving the med cart unattended to administer the medication to the resident.

An interview held with the DOC confirmed that the medication cart and E-MAR screen is to be kept locked at all times when the cart is left unattended and the RN did not protect resident #035's privacy related to his/her medication administration record. [s. 3. (1) 11. iv.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

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

Record review of an identified CIS report and progress notes revealed on an identified date resident #033 fell from his/her wheelchair. The fall was unwitnessed and the resident sustained an identified injury.

Further review of resident #033's fall incident record, post fall assessment and the plan of care indicated the wheelchair had a seatbelt that the resident was able to undo on his/her own. As one of the fall prevention interventions, the seatbelt was equipped with an alarm to alert staff when the resident removed the seatbelt, and staff had to ensure that the alarm was turned on. At the time of the fall, the seatbelt alarm was not activated for the resident and it did not alarm.

Interviews with RN #110, ADOC #114, and the DOC confirmed the above mentioned incident and that the seatbelt alarm was not turned on as specified in the resident's plan of care. [s. 6. (7)]

2. The home submitted a CIS report on an identified date indicated resident #048 had been sent to hospital on an identified date, for further assessment as the resident's health had declined post application of a medical device performed by an identified registered nurse. The resident returned to the home 14 days later after receiving treatment and care of an identified injury from a traumatic application of a device received during an identified shift and date.

The home's Resident Care Procedures/Treatments policy, #RESI-07-09-02, dated December 2002, states "the physician may order a specimen to be collected when there is a change in the resident's condition". The procedure section of the policy directs staff to "obtain an order from physician" for the collection procedures.

A review of resident #048's clinical records revealed that on an identified date, the physician had ordered an identified specimen to be collected, however, no order had been obtained for the application of a medical device to retrieve the specimen.

The progress notes for resident #048 were reviewed and revealed that at an identified time on an identified date resident #048 had been applied a medical appliance to obtain the required specimen as ordered. During the next identified shift the appliance was removed by the charge nurse and RPN #143 as the resident complained of pain and blood was found at the appliance site. The notes indicated that the resident was sent to hospital for further assessment and returned to the home 14 days later, after receiving treatment and care of an identified injury from a traumatic application of an identified medical appliance that occurred on an identified date.

An interview with RN #160 indicated that on an identified date and time, he/she applied a medical appliance to resident #48 to obtain a specimen as ordered. The RN indicated that he/she responded to a communication note that had been written by the day shift RPN #161 to conduct an identified procedure to resident #048 at the beginning of the identified shift of the above mentioned date.

Interviews with RN #160, RPN #161, the DOC and ADOC #114 indicated that there had been no order received by the physician to conduct any procedure to resident #048. The

DOC and ADOC #114 confirmed that on the above mentioned identified date, resident #048 had received an identified procedure conducted by an identified registered nurse without a physician's order and therefore the care set out in the resident's plan of care had not been provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that staff who provided direct care to a resident are kept aware of the contents of the plan of care.

Record review of resident #003's plan of care and interviews with PSW #150, RPN #148 and the DOC revealed the resident required a total mechanical Hoyer lift with two-person assist to transfer in and out of bed.

Record review of resident #003's progress notes and home's investigation record, along with interviews with resident #003 and a family member indicated on an identified date, PSW #152 had transferred resident #003 to bed using a sit-to-stand mechanical lift without a second staff member to assist. During the transfer, the resident landed forcefully on bed against the pillow and complained of pain to an identified area.

Interview with PSW #152 indicated on the above mentioned identified date, he/she transferred the resident to bed using a sit-to-stand mechanical lift alone because the other co-worker was on break. The staff member confirmed he/she had not been aware of the plan of care indicating that a total mechanical Hoyer lift should have been used to transfer the resident and not a sit to stand lift. [s. 6. (8)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #010 was triggered in stage two for worsening skin integrity. Documentation review indicated resident #010 developed an identified altered skin integrity acquired in the home.

A review of the written plan of care, with the last care plan review date did not contain changes in skin condition and altered skin integrity in the plan of care for resident #010.

An interview with the home's Wound Care Champion (WCC) #119 revealed if a resident is found with altered skin integrity the written plan of care is updated to reflect the changes in resident's skin condition. The WCC further confirmed the plan of care had not

indicated resident #010's identified altered skin integrity.

An interview with the DOC confirmed resident #010 did have identified altered skin integrity and the written plan of care did not reflect the altered skin integrity of resident #010. The DOC further indicated as per the home's skin and wound protocol, changes in skin integrity is to be reflected in the plan of care and the plan of care is to be updated with changes in residents' care requirements as they occur. [s. 6. (10) (b)]

5. The home submitted a CIS on an identified date for an unexpected death of a resident. The home contacted the MOH's after hours line on the day of the incident. The CIS further indicated that resident had two falls in the previous 24 hours, which had been his/her first since admission in 2015.

A review of resident #062's clinical records indicated that the resident had been admitted to the home on an identified date. Interviews with direct care staff indicated that from the time of the resident's admission the resident had been cognitively well, walked independently with a walker and had been identified as a low fall risk.

Resident #062's plan of care revealed that he/she had signed an advanced care directive on admission that directed staff to transfer the resident to acute care with Cardio Pulmonary Resuscitation (CPR) in the event that it is required. Interviews with ADOC #114 and the Social Worker (SW), further indicated that the advance care directives also directed staff to transfer any resident to hospital with any change of condition and contact their substitute decision maker.

A review of the progress notes for resident #062 for the three days prior to his/her unexpected death, revealed that the resident had sustained two falls within five hours of each of the falls.

A review of the head injury routine form that had been commenced after the second fall for resident #062 revealed elevated pulse rates.

An interview with RN #127 confirmed that he/she had assessed resident #062's vital signs at an identified time. The RN further revealed that he/she did not take the resident's pulse and vital signs two of the scheduled times as the resident had been sleeping. The RN indicated that he/she had assessed the resident's vital signs two hours later when he/she had administered an identified analgesic for complaints of pain. When asked if he/she had been concerned about the resident's change in condition of

increased pulse rates, RN#127 stated that he/she had not been concerned because he/she had chosen to use only his/her initial assessment of the elevated rate taken at the start of shift as the base line.

An interview with PSW #126 reported that resident had rang the call bell at approximate identified time and had assisted resident #062 to the washroom and back to bed. PSW #126 further reported that the resident was very shaky, unsteady and not able to carry on a conversation as usual. When asked if he/she reported this to RN #127, PSW #126 indicated that RN #127 was in the room at the same time following up on the analgesic previously administered. PSW #126 indicated that at this time the resident appeared to be weak and not his/her usual self, prompting him/her to ask the resident if he/she wanted to go to the hospital. The PSW stated that the resident had been unable to respond due to the resident's change in condition. The PSW further indicated that both he/she and the RN left resident #062's room at this time to answer another call bell.

RN #127 revealed that he/she was called to resident #062's room approximately one hour later by PSW #126. At that time RN #127 observed resident to be faced down on the floor. RN #127 then indicated that three staff members lifted resident #062 back to bed where the vital signs were assessed and were absent.

An interview with the DOC confirmed that resident #062 did have a change in condition on the above mentioned identified date, following the resident's two consecutive unwitnessed falls and weakened condition observed. The DOC further confirmed that the plan of care for resident #062 had not been reviewed and revised when the above mentioned resident care needs had changed. [s. 6. (10) (b)]

6. The licensee has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The home submitted a CIS Report on an identified date in 2014, which indicated resident #036 had been observed with his/her hands touching resident #037's clothing.

Documentation review of resident #036's chart indicated the resident was admitted with responsive behaviours.

The plans of care with the last care plan review completed in quarterly review A and

quarterly review B, did not show revisions of the plan of care were carried out when the set plan was not effective.

An interview with RN #110 confirmed and indicated resident #036's responsive behaviour interventions where not reassessed as the interventions set out had not been effective and the resident continued to demonstrate the responsive behaviour.

An interview with the ADOC #114 confirmed the plan of care for resident #036 had not been been reviewed and revised when the care set out in the plan of care had not been effective. [s. 6. (11) (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:
-the care set out in the plan of care is provided to the resident as specified in the plan,
-staff who provide direct care to a resident are kept aware of the contents of the plan of care,
-resident's are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, and
-when a resident is reassessed and the plan of care reviewed and revised because the care set out in the plan has not been effective, that different approaches to care are considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Record review of an identified CIS report and progress notes revealed on an identified date when PSW #152 transferred resident #003 to bed, the PSW lifted the resident's legs while the resident was sitting on the bed. As a result, the resident landed forcefully on bed against the pillow and complained of pain. Further review of the progress notes and home's investigation record revealed the PSW performed the transfer using a sit to stand mechanical lift without a second staff member to assist.

Record review of resident #003's plan of care and interviews with PSW #150, RPN #148 and the DOC indicated the resident required a total mechanical Hoyer lift with two-person assist to transfer in and out of bed.

Interviews with resident #003 and a family member indicated that on the above mentioned identified date, PSW #152 used a sit-to-stand lift to transfer the resident from washroom to bed alone. When the resident was put on bed, the staff member lifted his/her legs up and the resident fell on the bed with his/her head landing on the pillow. The resident complained of pain for a few days.

Interview with PSW #152 indicated that on the above mentioned date, he/she was asked by the resident to transfer him/her from the wheelchair to the bed. The PSW transferred the resident using a sit-to-stand mechanical lift by himself/herself as the coworker was on break. Interviews with PSW #152 and the DOC indicated the safe transfer technique when using the mechanical lift should be two-person assist with one staff member maneuvers the lift and another staff member supports the resident. The staff members confirmed the safe transferring and positioning techniques were not performed when transferring resident #003. [s. 36.]

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 that ensures staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During a dining observation on an identified home area resident #030 was observed not sitting upright in his/her wheelchair at the dining room table. The resident's head was resting between the headrest and the back of the wheelchair, his/her upper body was leaning backward at approximately 45 degrees, half of his/her thighs were outside the seat of the wheelchair, and his/her feet were not supported by the footrests. PSW #100 was observed to approach resident #030 and began to feed the resident without repositioning him/her.

Record review of resident #030's plan of care indicated the resident had cognitive and physical impairments and required total assistance for eating and repositioning.

An interview with PSW #100 indicated resident #030 required total assistance for eating and his/her safe positioning while eating was sitting upright with his/her head and legs properly supported on the wheelchair. The staff member confirmed he/she did not reposition the resident when feeding the resident and safe positioning of the resident had not been provided. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

The home submitted a CIS report on an identified date which indicated resident #036 had inappropriate responsive behaviours toward other residents..

The home's policy "Responsive Behaviours", policy number: 09-05-01 with the date of origin: September 2010 indicated Dementia Observation Scale (DOS) as being one of the resident assessment tools used within the home to assess behaviours. Procedure #4 indicates: Homes without Point of Care, the Responsive Behaviour Record or the DOS form is to be used by Care staff to record behavioural observations.

Documentation review indicated that on an identified date staff were instructed to document resident #036's behaviours using the Dementia Observation Scale (DOS) form. Review of the resident's DOS charting documentation indicated gaps in the DOS charting and for the identified week duration it had not been completed on all shifts.

Interviews with RN #110 and ADOC #114 indicated that it is the home's policy that DOS charting is to be started and completed on all shifts corresponding to the resident's activity at the time of observation. The RN and ADOC confirmed resident #036's DOS charting had not been completed as required by policy. [s. 8. (1) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred, immediately reports the suspicion and the information upon which it was based to the Director. 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.

A review of an identified CIS report revealed that a visitor had observed and reported PSW #126 speaking to resident #038 in an inappropriate manner and had raised his/her fist, and that the resident appeared to be threatened by the staff member. The incident occurred on an identified date and had been reported to ADOC #146 one day later.

Interviews with the HRA and the DOC confirmed the above mentioned, and the DOC further confirmed the incident was not reported to the Director immediately as required. [s. 24. (1)]

WN #8: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, an interdisciplinary assessment of the resident's sleep patterns and preferences.

A review of resident #002's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessments on an identified date revealed the resident had a an identified cognitive performance scale (CPS) level and was bedfast for all or most of the time. The most current RAI-MDS assessment revealed the resident was not bedfast for all or most of the time.

A review of the resident's most current plan of care indicated the resident bedfast most of the time.

Interviews with PSW #101, #102, and RPN #104 indicated the resident's preference was to stay in bed most of the day and usually gets up for lunch. Staff would have to ask the resident for his/her choices. An observation during the inspection indicated the resident was up in the dining room for lunch.

Further review of the resident's plan of care indicated, and interviews with PSW #102 and RPN #104 confirmed that the plan of care did not mention the resident's sleep patterns and preferences in relation to getting up for lunch. [s. 26. (3) 21.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home submitted an identified CIS on an identified date for an unexpected death of a resident. The home contacted the MOH's after hours line on the day of the incident. The CIS further indicated that resident had two falls in the previous 24 hours, which had been his/her first since admission in 2015.

Review of home's policy titled Falls Prevention and Management Program (RESI-10-02-01, Version: April 2013) states that "Registered staff are to complete a post fall assessment after every fall".

A review of resident #062's progress notes and an interview with RPN #137 indicated that on an identified date and time RPN #137 had been called by a PSW to report that resident #062 was found on the floor. RPN #137 indicated that he/she had initiated a head injury routine form at the time of the fall, however, confirmed that he/she did not complete a post fall assessment using a clinical assessment tool, as required by the above mentioned policy.

An interview with the DOC indicated that the expectation is for all registered staff to complete the home's clinical post fall assessment tool for all resident falls. The DOC further confirmed that resident #062's had not been assessed using the home's clinical assessment tool as required for the above mentioned fall. [s. 49. (2)]

WN #10: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstance of the resident require, and assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A review of resident #009's RAI-MDS assessment and the admission continence assessment on an identified date, revealed the resident was continent of bladder and bowel. Further review of the RAI-MDS assessment dated three months after the initial identified date, revealed the resident was occasionally incontinent in bladder.

Record review of the resident's clinical assessment record indicated the resident did not receive an assessment of incontinence when his/her bladder continence had changed to occasionally incontinent in the second identified date mentioned above.

Interviews with PSW #112, RPN #113, and ADOC #114 indicated the resident was occasionally incontinent of bladder. The RPN and ADOC confirmed the resident did not

receive an assessment that includes the identification of causal factors, types of incontinence, and potential to restore function with specific interventions. [s. 51. (2) (a)]

2. The licensee had failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

A review of resident #009's RAI-MDS assessment and the admission continence assessment on an identified date revealed the resident was continent of bladder and bowel. Further review of the RAI-MDS assessment dated three months after the identified date, revealed the resident was occasionally incontinent of bladder and had been wearing continence care products. A review of the resident's plan of care indicated no mention of care in relation to the resident's bladder incontinence.

Interviews with PSW #111, RPN #113 and ADOC #114 indicated the resident was occasionally incontinent of bladder and the resident was independent for toileting. PSW #111 indicated the resident wears a continence care product.

ADOC #114 indicated the resident would be a good candidate for restorative care toileting program and the home was working with the new physiotherapy services provider to start up the program. RPN #113 and ADOC #114 confirmed the resident did not have a plan of care to promote and manage bladder continence as required. [s. 51. (2) (b)]

WN #11: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed, of an incident that caused an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Record review of an identified CIS report and progress notes revealed on an identified date resident #033 fell from his/her wheelchair. An x-ray was ordered and the results indicated suspicious crack fracture of an identified area and the resident was taken to hospital on the same day. The incident was reported to the Ministry of Health Director seven days later.

Interviews with ADOC #114 and the DOC confirmed the above mentioned incident was reported seven days after the incident and not within one business day as required. [s. 107. (3) 4.]

Issued on this 7th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202), JENNIFER BROWN (647), MATTHEW CHIU (565), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2016_168202_0013
Log No. / Registre no:	012039-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 12, 2016
Licensee / Titulaire de permis :	SOUTHLAKE RESIDENTIAL CARE VILLAGE 640 GRACE STREET, NEWMARKET, ON, L3Y-2L1
LTC Home / Foyer de SLD :	SOUTHLAKE RESIDENTIAL CARE VILLAGE 640 GRACE STREET, NEWMARKET, ON, L3Y-2L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anne Deelstra-McNamara

To SOUTHLAKE RESIDENTIAL CARE VILLAGE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

Upon receipt of this order the licensee shall:

1. The licensee shall develop and submit a plan that includes the following requirements and the person responsible for completing the tasks. The plan is to be submitted to valerie.johnston@ontario.ca by September 30, 2016, and implemented by November 30, 2016.

2. Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents.

3. The policy review and training shall include all definitions of abuse, and not be limited to neglect, as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

4. At the end of the review, staff shall be able to recognize and define all forms of abuse under the legislation.

Grounds / Motifs :

1. The licensee has failed to ensure that the residents are protected from abuse by anyone and free from neglect by the licensee or staff.

The Long Term Care Homes Act, 2007. O.Reg 79/10, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a CIS on an identified date indicating that resident #048 had been sent to hospital for further assessment as the resident's health had declined after the insertion of a medical appliance. The resident returned to the home in 14 days after receiving treatment and care of an identified injury resulting from a traumatic application of an identified appliance performed by a registered nurse on an identified shift and identified date.

A review of resident #048's clinical records revealed that on an identified date the physician had ordered an identified specimen to be collected for lab testing. The progress notes for resident #048 were reviewed for 24 hours post physician order and revealed the following:

-Time A: Resident #048 had received application of an identified medical appliance by a RN. The resident became agitated during the procedure and an identified analgesic had been given for discomfort.

-Time B: The resident complained of pain and analgesic was given and the resident's facial colouring was pale.

-Time C: Charge nurse was advised that the resident had received an identified procedure and application of an identified appliance, had discomfort and blood was present at the procedural site.

-Time D: The resident was assessed for results from the application of the identified appliance with scant blood located at the appliance site. The device was removed by charge nurse and resident was observed to have a bloody discharge for 30 minutes from the identified appliance site. Resident was sent to hospital soon after.

A review of the hospital consultation notes from resident #048's hospitalization stated that the resident had received a procedure and application of an identified medical appliance in his/her nursing home and that the appliance had been possibly placed incorrectly.

An interview with RN #160 revealed that at the beginning of his/her shift, he/she had read direction posted by the earlier shift Registered Practical Nurse (RPN) in the communication book directing him/her to complete a procedure to obtain an identified specimen for lab testing. The RN stated that at an approximate time, with the assistance of PSW #163, completed the identified procedure. The

RN further stated that he/she had been unaware at the time of the procedure that a physician's order had not been obtained and had he/she known would not have conducted the procedure and the application of the identified appliance.

RN #160 indicated that during the procedure resident #048 had grabbed his/her hand and indicated that he/she was in pain. The RN further indicated that he/she recognized the resident was in pain, continued to proceed with the procedure and provided the resident with an identified analgesic to reduce his/her pain. The RN stated that he/she then requested the PSW to monitor the resident.

PSW #163 no longer an employee of the home had been identified as having assisted RN #160 with resident #048's identified procedure. Attempts had been made to contact the PSW by the inspector; however, contact could not be made. As a result, interviews were conducted with Assistant Director of Care (ADOC) #114 and the Human Resource Advisor (HRA) in order to obtain PSW #163's statement and details of the interview conducted by the home.

ADOC #114 and HRA #164 indicated that during the home's investigation PSW #163 had provided the home with a statement of events that occurred during the identified shift and date. The HRA stated that PSW #163 had confirmed assisting RN #160 with the application of the identified medical appliance, at the beginning of the identified shift. Both the HRA and ADOC #114 indicated that PSW #163 had been directed by the RN to monitor the resident; however, the PSW had stated in his/her statement that he/she only monitored to ensure that the resident did not remove the identified appliance.

An interview with RPN #143 indicated that on the above identified date, RN #160 provided him/her with a brief report at the start of his/her shift, indicating that resident #048 had an identified medical appliance in place and that there had been no results from the placement of the appliance. The RPN further indicated that at approximately one and a half hours later, he/she went to check on the resident, noticed that the appliance was in place and that the resident remained with no results. Approximately two hours later, the RPN indicated that the resident appeared to be uncomfortable and blood had been found around the appliance site. At approximately one half hour later, the RPN and the RN in charge completed an assessment and the RPN stated that at this time, they had removed the identified appliance and the resident had been observed a bloody discharge for approximately 30 minutes. The resident was then sent to hospital for further assessment.

When asked of RN #160 whether resident #048 had been assessed at any time during the identified shift and date, the RN indicated that he/she was not able to assess the resident as much as he/she should have because the identified shift was busy. The RN stated that he/she had performed an identified procedure and application of a medical device to resident #048 at the beginning of the shift and asked PSW #163 to monitor the resident.

Interviews with the DOC and ADOC #114 indicated that upon completion of the home's investigation confirmed that resident #048 had been neglected by RN #160 during the identified shift of the above mentioned identified date, as the RN failed to complete additional assessments after the application of the medical appliance. Both the DOC and the ADOC further stated that RN #160 did not recognize that the identified medical appliance had not been successful for at least six hours and failed to act, placing resident #048's health at risk and in addition had not obtained a physician's order to apply the identified appliance.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

At the beginning of an identified shift of an identified date, RN#160 performed an identified procedure and application of an identified appliance to resident #048 without a physician's order and failed to act, assess and provide the appropriate care and treatment post procedure. The RN confirmed that he/she failed to act and provide care to resident #048 when required and as a result the resident required hospitalization for treatment and care of the identified diagnosed injury resulting from a traumatic identified procedure.

The scope of the non-compliance is isolated to resident #048.

The home has previously been issued a Voluntary Plan of Correction (VPC), under LTCHA, 2007,. c.8, s. 19 (1), on October 15, 2016, within report #2015_168202_0021. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

Upon receipt of this order the licensee shall:

1. The licensee shall develop and submit a plan that includes the following requirements and the person(s) responsible for completing the tasks. The plan is to be submitted to valerie.johnston@ontario.ca by September 15, 2016, and implemented by October 14, 2016.

2. Within one week of receipt of the order conduct a meeting between management and direct care staff from home area 2 East.

3. The meeting shall allow direct care staff opportunities to review resident #048's plan of care to allow for the development of strategies and interventions that will ensure that resident #048 receives the care in a manner consistent with his/her needs, related to safe transfer and positioning techniques.

4. The development of the plan of care must include participation from resident #048's Substitute Decision Maker (SDM) and include developed strategies to respond to resident #048's transfer needs in a timely manner.

5. Senior management must communicate the importance of the SDM not transferring the resident to both the staff and the SDM.

Grounds / Motifs :

1. The licensee has failed to ensure that the right of every resident to be properly

sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs had been fully respected and promoted.

The home submitted a Critical Incident Report (CIS) report on an identified date, indicating that resident #048 had been found in bed expressing discomfort. The resident was then transferred to hospital for further assessment and returned to the home on the next day, diagnosed with identified injuries of an identified area of the body. The report further indicated that the Substitute Decision Maker (SDM) for resident #048 had been upset and expressed that the resident may have been harmed by staff during a transfer. The home investigated the incident and confirmed that there was no causal incident to warrant the identified injury and that the injuries were pathological in nature.

A review of resident #048's clinical records revealed that the resident had been admitted to the home on an identified date in 2014. A review of resident #048's written plan of care directed staff to use two staff assistance for all Hoyer mechanical lift transfers, one staff to position and supervise the resident for safety and one to maneuver the Hoyer lift. The plan of care also directed staff to provide toileting assistance with two staff present, one staff to support and position the resident and one staff to complete tasks of product changes and hygiene.

Resident #048's progress notes indicated that at an identified time and date, while the resident was in bed, the resident screamed out in pain when staff attempted to assist him/her from the bed and was sent to hospital for further assessment. The resident returned to the home the following day diagnosed with two identified injuries.

All direct care staff who had worked prior to the identified injury and post identified injury, those assigned to resident #048 and those who had worked on the identified home area were interviewed. All staff interviewed did not reveal an incident or occurrence that would have caused the two identified injuries, however, revealed the following:

PSW #139 indicated that he/she provides care to resident #048 on an identified shift with another staff member as directed in the plan of care. The PSW revealed that he/she had heard reports that resident #048's SDM had transferred the resident by him/herself using the Hoyer mechanical lift, however, had not witnessed this.

PSW #140 stated that resident #048's SDM is actively involved in the resident's care and has found the resident already in bed after lunch when prompted to provide the resident with care. The PSW further stated that he/she although he/she has told the SDM not to transfer the resident; the SDM had indicated that "he/she likes to take care of resident #048".

PSW #101 revealed that he/she is the primary PSW assigned to resident #048 and is responsible for the resident's care and transfers. The PSW stated that the resident is transferred to bed after lunch every day, however, the time varies dependent upon if the SDM takes the resident off the home area for a walk or outing and whether he/she has first or second break. The PSW stated that his/her break time changes every second week, one week he/she has the earlier break and the next he/she has the later break. The PSW indicated that every second week when he/she has the later break, the SDM will transfer the resident to bed using the Hoyer lift by herself because the SDM does not like to wait. PSW #101 revealed that resident #048's SDM has transferred the resident by him/herself using the Hoyer mechanical lift from the time that the resident had been admitted.

PSW #142 indicated that he/she had been assigned to resident #048 for an identified shift. The PSW further indicated that he/she has witnessed resident #048's SDM transfer the resident to bed by him/herself using the Hoyer mechanical lift. PSW #142 revealed that resident #048's SDM will often take the resident off the home area after dinner and will transfer the resident to bed and provide his/her personal care, not wanting to wait for staff assistance. PSW #142 indicated that the SDM has been told not to transfer the resident and most notably after the resident's diagnosed injuries of the identified above mentioned date.

RPN #143 indicated that resident #048's SDM had transferred the resident using the mechanical lift many times. The RPN stated that he/she had walked into resident #048's room while the SDM was transferring the resident and had tried to stop him/her. The RPN indicated that the SDM had been told it is not safe to transfer the resident by him/herself, however, continued to do so.

RPN #104 stated that resident #048's SDM is very involved in the resident's care and had transferred the resident using the mechanical lift by him/herself. The RPN stated that at an approximate time ago, he/she had found the SDM

transferring the resident by him/herself using the mechanical lift, even after the awareness of the resident's identified injuries and had been told not to.

Resident #048's progress notes were reviewed from the resident's time of admission which revealed three documented incidents of resident #048's SDM observed to transfer the resident using the mechanical lift.

An interview with resident #048's SDM revealed that he/she had been transferring and providing care to the resident using the Hoyer mechanical lift by him/herself from the time that the resident had been admitted to the home. The SDM indicated that he/she would like the resident to go to bed after meals and that he/she does not like to wait for staff and that some staff do not transfer the resident properly.

A review of the home's Safe Lifting with Care Program, Mechanical Lifts policy, #01-02 revised May 2009, states "only staff trained and competent in the use of Mechanical Lifts will perform resident transfers using this equipment. Two trained staff are required at all times when performing a Mechanical Lift".

Interviews with the DOC, ADOC #114 and ADOC #146 indicated that they only became aware that resident #048's SDM had been transferring the resident by him/herself using the Hoyer mechanical lift through the home's investigation of resident #048's identified injuries diagnosed on the above mentioned date.

ADOC #146 was further interviewed during the course of the inspection. When asked whether the home had interventions in place to ensure that the resident is transferred by staff and in accordance to the resident's assessed care needs, the ADOC indicated that the SDM has been told to not transfer the resident and that staff are to monitor for any transfers conducted by the SDM, document and report to the supervisor. When asked whether he/she was aware that the SDM had attempted to transfer the resident on an identified recent date, the ADOC indicated that he/she only became aware of it recently.

The licensee has failed to ensure that resident #048 had been provided transferring assistance with two staff and a mechanical lift for all transfers from the time the resident had been admitted. The DOC, ADOC #114 and ADOC #146 all confirmed that resident #048's right to be cared for in a manner consistent with his/her needs had not been fully respected and promoted and as a result placed resident #048 at risk of injury.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #048 was diagnosed with identified injuries on an identified date. Interviews with direct care staff confirmed that from the time of resident #048's admission in 2014, the resident had been continually transferred by the resident's SDM from wheelchair to bed using a Hoyer mechanical lift alone. Resident #048's care needs required him/her to be transferred using a Hoyer mechanical lift with two staff present at all times. Management of the home became aware of the SDM's transferring practices during the home's investigation of the resident's identified injuries and as a result the SDM was made aware of the risks associated with him/her transferring the resident and staff were directed to document and report any further incident. Records and staff interviews indicated that the SDM attempts to continually transfer the resident and most recently the SDM had been observed by RPN #143 to be in mid transfer from wheelchair to bed. At the time of the inspection the licensee failed to provide interventions to ensure that resident #048's right to be cared for in a manner consistent with his/her needs.

The scope of the non-compliance is isolated to resident #048.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007., c.8. s. 3.: A voluntary plan of correction (VPC) was previously issued under LTCHA, 2007., c.8., s. 3 (1) 1, s. 3 (1) 3 and s. 3 (1) 9, during a Resident Quality Inspection (RQI) issued to the home on January 16, 2015, under Inspection #2015_297558_0001.
(202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de 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 12th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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