Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 16, 2016	2016_341583_0022	030112-16	Resident Quality Inspection

Licensee/Titulaire de permis

HALDIMAND WAR MEMORIAL HOSPITAL
206 JOHN STREET DUNNVILLE ON N1A 2P7

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

EDGEWATER GARDENS LONG TERM CARE CENTRE
428 BROAD STREET WEST DUNNVILLE ON N1A 1T3

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

KELLY HAYES (583), ROSEANNE WESTERN (508)

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): October 14, 17, 18, 19, 21 and 24, 2016.

The following inspections were conducted simultaneously with this Resident Quality Inspection:
Critical Incident Inspection log #026905-15 related to an unsafe transfer, log #007554-16 related to alleged neglect, log #017983-16 related to fall with significant change, and log #029284-16 related to fall with significant change.
Complaint Inspection log #022789-15 related to staffing, safe and secure home and resident care.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (Administrator/DOC); Programs Manager; Food Service Manager; Physiotherapist (PT); Registered Nursing staff (RN/RPN); Personal Support Workers (PSW); family members and residents. During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.

- **13 WN(s)**
- **6 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents, annual retraining in accordance with O. Reg. 79/10, s. 219(1), in relation to the following: Behaviour management.

The Administrator/DOC confirmed that staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that training had not been provided in the area of behaviour management. It was confirmed that training for Behaviour management had not been initiated for 2016 at the time of the inspection. (583) [s. 76. (7) 3.]

2. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents, annual retraining in accordance with O. Reg. 79/10, s. 219(1), in relation to the following: How to minimize the retraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations.

The Administrator/DOC confirmed that staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that training had not been provided in the area of how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. It was confirmed that training for minimizing of restraining had not been initiated for 2016 at the time of the inspection. [s. 76. (7) 4.]

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 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 failed to ensure that when the resident had fallen, the resident was assessed and, when required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

1) Resident #200 had a fall on an identified date in June 2016, which resulted in an injury. The resident was transferred to hospital for further assessment and treatment of their injuries. The resident was hospitalized for a specified amount of time and was re-admitted back to the home for palliative care. The resident died three days later.

A review of the resident's clinical records indicated that after the fall, staff conducted a fall risk assessment and an internal incident report. The fall risk assessment was used to determine the level of risk a resident was at for falls and the internal incident report form was used for all incidents in the home involving residents, not designed specifically for falls.

It was confirmed during an interview in October 2016, with the Administrator/DOC that a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls was not conducted when residents fell. (508)

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident (CI) inspection, log # 017983-16, conducted concurrently during this Resident Quality Inspection.

2) Resident #300 had a fall on an identified date in September 2016, which resulted in an injury. The resident was transferred to hospital for further assessment and treatment of their injuries.

A review of the resident's clinical records indicated that after the fall, staff conducted a fall

risk assessment and an internal incident report. The fall risk assessment was used to determine the level of risk a resident was at for falls and the internal incident report was a form used for all incidents in the home involving residents, not designed specifically for falls.

It was confirmed during an interview in October 2016, with the Administrator/DOC that a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls was not conducted when residents fell. (583)

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident (CI) inspection, log # 029284-16, conducted concurrently during this Resident Quality Inspection.

3) Resident #108 had falls on four identified dates in August 2016. A review of the resident's clinical record indicated that no post-fall assessments were conducted using a clinically appropriate assessment instrument as the home has not implemented a post-fall assessment instrument specifically designed for falls.

It was confirmed during an interview in October 2016, with the Administrator/DOC that a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls was not conducted when residents fell. (508) [s. 49. (2)]

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 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).**

Findings/Faits saillants :

1. The licensee failed to ensure that when required residents were assessed using a clinically appropriate assessment instrument specifically designed for the assessment of continence.

During a family interview with resident #201's substitute decision maker (SDM) on an identified date in October 2016, it was identified resident #201 had a significant decline in their level of continence. The SDM shared they had visited the resident and observed signs of continence care needs not being met. A review of the RAI-MDS continence assessment completed on an identified date in September 2016, identified resident #201 declined from frequently incontinent to incontinent.

After a review of the resident's clinical records it was identified that a continence care assessment using a clinically appropriate assessment instrument was not completed on admission or where circumstances required. Resident #201's clinical records did not contain records that identified causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

In an interview in October 2016, with the Administrator/DOC it was confirmed that an assessment using a clinically appropriate assessment instrument specifically designed for the assessment of continence was not completed for resident #201. It was confirmed that the home did not have a clinically appropriate assessment instrument for continence developed or implemented at the time of the inspection. [s. 51. (2) (a)]

Additional Required Actions:

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

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

On an identified date in 2015, resident #201 was being transferred from their wheelchair to bed with two staff using a mechanical ceiling lift. During the transfer the resident slid out of the sling and fell onto the floor causing an injury.

A review of the resident's clinical record and the home's internal investigative notes revealed that the PSW did not stay to guide the resident during the transfer. The PSW was not positioned in the correct place to monitor the transfer when the bottom straps of the sling may have slipped off.

It was confirmed during an interview with the Administrator/DOC and through review of the home's documentation that the staff did not use safe transferring and positioning devices or techniques when assisting resident #201.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log #026905-15, conducted concurrently during this RQI. [s. 36.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provide care to the resident.

A) Resident #102 had a specific device that was to be applied while in their wheelchair to minimize the resident's risk of falling. A review of the resident's clinical record revealed that the resident's restraint plan of care directed registered staff to sign the need for this restraint every 12 hours. The Medication Administration Record (MAR) directed registered staff to sign for the restraint every shift which was confirmed to be every eight hours, not every 12 hours.

The MAR directed staff to sign every shift; however, there were only two times during a 24 hour period set up on the MAR for registered staff to sign. This information was

confirmed by the Administrator/DRC in October 2016, during an interview.

Documentation reviewed on the resident's plan of care and the MAR also confirmed that the plan of care did not set out clear directions to staff and others who provided care to the resident. (508)

B) Resident #101 was a total assistance for personal hygiene which included mouth care twice a day. A review of the resident's plan of care under the focus of personal hygiene indicated that the plan directed staff to maintain the resident's daily appearance and that the resident required assistance with mouth care.

The intervention for mouth care in the plan directed staff to apply toothpaste on toothbrush, brush teeth and to wash the toothbrush well after each use. The plan did not provide direction as to how frequently the mouth care was to be done.

The frequency of when to complete mouth was missing on the kardex and the point of care (POC) section that Personal Support Workers (PSW) use for direction and to document care provided to residents.

It was confirmed during an interview with the Administrator/DOC that the written plan of care did not set out clear directions to staff and others who provided care to the resident. (508)

C) Resident #104 was observed on an identified date in October 2016, wearing a specified restraint while up in their wheelchair. A review of the plan of care identified the resident had a specified restraint. The care plan directed registered staff to sign need for restraint every 12 hours. A review of the treatment administration record identified registered nursing staff were signing off on "restraint in wheel chair for patient safety when up", every eight hours.

In an interview with the Administator/Director of Care in October 2016, it was confirmed that resident #104's plan of care did not clearly direct the registered nursing staff to reassess the resident's condition and the effectiveness of the restraining at least every eight hours, or at any other time when necessary based on the resident's condition or circumstances. (583)

D) During a family interview with resident #103's substitute decision maker on an identified date in October 2016 it was identified resident #103 had a significant change in

their level of incontinence. A review of the clinical record identified resident #103 was incontinent of urine. The care plan contained two different sets of instructions. It directed staff to toilet resident #103 in the morning and before and after meals and it also directed staff to toilet resident #103 in the morning and evening and before and after meals and programs. A review of the Point of Care toilet task did not contain direction as to what times resident #103 required toileting.

During an observation on an identified date in October 2016, resident #201 was not toileted after lunch. In an interview with PSW #030 and #055 it was shared with Inspector #583 they were not clear what times resident #201 was to be toileted. In an interview with the Administrator/DOC in October 2016, it was confirmed that it was not known what toileting times were needed to meet the resident's needs and that the direction in the resident's care plan was not clear. (583) [s. 6. (1) (c)]

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

A review of resident #101's plan of care for recreation and social activities indicated that the resident had a desire to attend spiritual services and enjoyed music group therapy. The goals were to have the resident attend one to two spiritual services per week and to attend music entertainment programs.

Resident #101 had cognitive impairment and was totally dependent on staff to transport them to and from areas of the home where activities were occurring. During the course of this inspection it was observed that resident #101 was sitting in their room during times when these programs were occurring within the home.

An interview with the Programs Manager in October 2016, it was confirmed that staff should have attempted to bring resident #101 to these programs and that care set out in the plan had not been provided to the resident as specified in the plan.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #022789-15, conducted concurrently during this RQI. [s. 6. (7)]

3. The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

In an identified date in 2016, a discussion was held between a family member of resident

#101 and the Physiotherapist (PT) regarding the resident's medical condition. The family member had requested that the resident have a specified intervention and the PT agreed to this intervention.

A review of the resident's plan of care indicated that this intervention had been implemented; however, had not been documented in the plan. A review of the Point of Care (POC) documentation also indicated that this provision of care had not been documented.

Review of the resident's plan of care and an interview with the PT in October 2016, confirmed that the provision of care set out in the plan of care had not been documented. [s. 6. (9) 1.]

4. The licensee 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 changed or care set out in the plan was no longer necessary.

Resident #108 was admitted on an identified date in 2015, with a diagnosis of a fracture to an identified area. The plan of care developed at the time of the resident's admission identified that the resident had pain related to the fracture and interventions were developed.

The resident's current plan of care and the most recent pain assessment indicated that the resident continued to have pain due to the fractured area.

The resident was interviewed by Inspector #508 during this inspection, and denied having any pain issues including the pain from their previous fracture. Registered staff #084 confirmed this information.

It was confirmed through documentation and interviews with the resident and staff #084 in October 2016, that the plan of care was not reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (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 written plan of care for each resident sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During this inspection, staffing schedules were reviewed for both registered and non-registered nursing staff. The RN schedules reviewed between the period of August 6 to October 24, 2016, revealed that on August 7, 12 and 23, 2016, there was no registered nurse (RN) on duty and present in the home on the evening shifts of these identified dates from 1500 hours to 2300 hours.

This information was confirmed during a review of the RN schedules and during an interview with the Administrator/DOC on October 24, 2016.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #022789-15, conducted concurrently during this RQI. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.

WN #7: 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 instituted or otherwise put in place is:
(a) in accordance with and is implemented in accordance with all applicable requirements under the Act.

During this Resident Quality Inspection (RQI), the Falls Prevention Policy, # N-5-65 was reviewed in relation to post fall assessment and management. It was identified that directions contained in this policy were not in compliance with O. Reg. 79/10, s. 49 (2).

After a resident had fallen, the policy directed registered staff to re-do the Fall Risk Assessment, complete an incident investigation, document in the progress notes and to complete an Internal Incident Report. It did not direct staff to conduct a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls where the condition or circumstances of the resident require.

It was confirmed by the Administrator/DOC during an interview on October 18, 2016, that this was the home's current policy for falls prevention and that the Internal Incident Report used post falls was used for all incidents and not specifically designed for falls. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were implemented to respond to these behaviours and actions taken to respond to the needs of the resident and the resident's responses to interventions were documented.

A review of the home's internal investigative notes identified resident #301 was found with their brief removed covered in stool on an identified date in 2016. Through interviews with front line staff and review of cameras it was identified staff #031 and #045 left resident #301's room at a specified time on the identified date in 2016, at which time staff were unable to complete the resident's continence care due to demonstrated responsive behaviours.

A review of the clinical record identified resident #301 had a specific responsive behaviour and the care plan directed staff to respond with a specific approach. In an interview with the Administrator/DOC in October 2016, it was confirmed that the staff did not implement the required strategy. It was confirmed the resident was left and not approached for four hours.

The progress note documented on the date of the incident by the registered nursing staff, stated "Rest/Sleep Note Text: Resident had a good night tonight, slept well". In an interview with the Administrator/DOC in October 2016, it was confirmed that resident #301's responsive behaviours, action taken to respond to the behaviour and the resident's responses were not documented during the shift the incident occurred.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #007554-16, conducted concurrently during this RQI. [s. 53. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, strategies are implemented to respond to the behaviours, where possible; and actions taken to respond to the resident, including interventions are the residents responses to the interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was restrained by a physical device under section 31 or section 36 of the Act, that staff applied the physical device in accordance with any manufacturer's instructions.

A) It was observed by Inspector #508 on a an identified date in October 2016, that

resident #102 was in their wheelchair with a device sitting loosely on the resident's lap. According to the manufacturer's instructions, the device must be worn tightly fitted across the lower pelvis or thighs at all times. A loose device can allow the user to slip down and create a risk of strangulation.

It was confirmed by the Administrator/DOC during an interview in October 2016, that the device was not applied according to the manufacturer's instructions. (508)

B) It was observed by Inspector #508 on an identified date in October 2016, that resident #104 was in their wheelchair with a device sitting loosely on the resident's lap. According to the manufacturer's instructions, the device must be worn tightly fitted across the lower pelvis or thighs at all times. A loose device can allow the user to slip down and create a risk of strangulation.

It was confirmed with staff #067 on an identified date in October 2016 and by the Administrator/DOC during an interview in October 2016, that the seat device was not applied according to the manufacturer's instructions. (583) [s. 110. (1) 1.]

2. The licensee failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Resident #102 had a restraining device on their wheelchair defined as a restraint to minimize the resident's risk of falls. A review of the resident's restraint plan of care revealed that the plan directed registered staff to sign the need for the restraint every 12 hours. Further review of the Medication Administration Record confirmed that the registered staff were only assessing and signing the need for the restraint every 12 hours.

It was confirmed by the Administrator/DOC during an interview on October 18, 2016, that the resident's condition and the effectiveness of the restraining was not reassessed or evaluated by registered staff at least every eight hours. [s. 110. (2) 6.]

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 staff apply physical devices in accordance with any manufacturer's instructions and to ensure the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 118. Information in every resident home area or unit
Every licensee of a long-term care home shall ensure that the following are available in every resident home area or unit in the home:
1. Recent and relevant drug reference materials.
2. The pharmacy service provider's contact information.
3. The contact information for at least one poison control centre or similar body.
O. Reg. 79/10, s. 118.

Findings/Faits saillants :

1. The licensee failed to ensure that the following were available in every resident home area or unit in the home:
1. Recent and relevant drug reference materials

On October 24, 2016, it was identified that drug reference materials were not available on the two resident home areas/nursing units in the home. The Administrator/DOC located one manual which was located in the office area of the home but could not locate the two reference manuals that had been distributed to the two nursing units.

It was later identified that the drug reference materials were made available on-line through the home's pharmacy provider; however, not all staff were made aware of this or had access to these materials.

This information was confirmed by the Administrator/DOC on October 24, 2016. [s. 118.]

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 recent and relevant drug reference materials are available in every resident home area or unit in the home, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #102 was scheduled to have a bath twice a week on specified days. A review of the resident's clinical record revealed that in October 2016, the resident did not receive their bath on an identified date in October 2016, and staff did not offer the resident another date or time to receive their bath. It was confirmed in an interview with the Administrator/DOC that on this date in October 2016, the home did not have their regular compliment of PSW staff.

It was confirmed by the Administrator/DOC during an interview in October 2016, that resident #102 did not receive the required two baths per week.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #022789-15, conducted concurrently during this RQI. [s. 33. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.

Resident #101 required total assistance with personal hygiene which included mouth care twice a day and the daily maintaining of appearance.

A review of the Point Of Care (POC) documentation between an identified period in October 2016, indicated that five days out of the 13 days the resident only received mouth care either in the afternoon or in the evening and not in the morning. The resident had refused mouth care on three occasions during this period but not on these identified dates.

It was confirmed through interviews and documentation that the resident did not receive mouth care in the morning on five specific days October 2016. [s. 34. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's drug destruction and disposal policy included that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

During this inspection it was observed on October 24, 2016, that controlled substances that were to be destroyed and disposed of were located in a single-locked cupboard in the first floor medication room. The Administrator/DOC confirmed that the cupboard was where all discontinued controlled substances were kept until they were disposed and that the cupboard only had one single lock. [s. 136. (2) 2.]

Issued on this 10th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2016_341583_0022
Log No. / Registre no:	030112-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 16, 2016
Licensee / Titulaire de permis :	HALDIMAND WAR MEMORIAL HOSPITAL 206 JOHN STREET, DUNNVILLE, ON, N1A-2P7
LTC Home / Foyer de SLD :	EDGEWATER GARDENS LONG TERM CARE CENTRE 428 BROAD STREET WEST, DUNNVILLE, ON, N1A-1T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Greg Allen

To HALDIMAND WAR MEMORIAL HOSPITAL, 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. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure that the following is completed.

1. Develop training for responsive behaviours and minimizing of restraining that is in accordance with this Act and the regulations.

2. Ensure all direct care receive the training.

The Order is made based upon the application of the factors of severity (2 - minimal harm or potential for actual harm), scope (2 - pattern) and compliance history (4 - ongoing non compliance with an order), and the Licensee's history of non-compliance with a CO on August 18, 2014.

Grounds / Motifs :

1. 1. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents, annual retraining in accordance with O. Reg. 79/10, s. 219(1), in relation to the following: Behaviour management.

The Administrator/DOC confirmed that staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that training had not been provided in the area of behaviour management. It was confirmed that training for Behaviour management had not been initiated for 2016 at the time of the inspection.

2. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents, annual retraining in accordance with O. Reg. 79/10, s. 219(1), in relation to the following: How to minimize the retraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations.

The Administrator/DOC confirmed that staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that training had not been provided in the area of how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. It was confirmed that training for minimizing of restraining had not been initiated for 2016 at the time of the inspection. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall ensure that the following is completed.

1. Develop a clinically appropriate post-fall assessment instrument that is specifically designed for falls.

2. Ensure that all residents receive a post fall assessment using the instrument when the condition or circumstances of the resident require.

3. Update the home's current Falls Prevention policy related to completing a post-fall assessment using the clinically appropriate assessment instrument.

4. The home shall implement the updated Falls Prevention policy and ensure that all registered staff receive education on their roles and responsibilities outlined in the updated policy.

5. Develop and implement an auditing system to ensure staff are assessing resident with the post fall assessment tool when required.

The Order is made based upon the application of the factors of severity (2 - minimal harm or potential for actual harm), scope (3 - widespread) and compliance history (4 - ongoing non compliance with a VPC), and the Licensee's history of non-compliance with a VPC on August 18, 2014.

Grounds / Motifs :

1. 1. The licensee failed to ensure that when the resident had fallen, the resident

was assessed and, when required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

1) Resident #200 had a fall on an identified date in June 2016, which resulted in an injury. The resident was transferred to hospital for further assessment and treatment of their injuries. The resident was hospitalized for a specified amount of time and was re-admitted back to the home for palliative care. The resident died three days later.

A review of the resident's clinical records indicated that after the fall, staff conducted a fall risk assessment and an internal incident report. The fall risk assessment was used to determine the level of risk a resident was at for falls and the internal incident report form was used for all incidents in the home involving residents, not designed specifically for falls.

It was confirmed during an interview in October 2016, with the Administrator/DOC that a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls was not conducted when residents fell. (508)

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident (CI) inspection, log # 017983-16, conducted concurrently during this Resident Quality Inspection.

2) Resident #300 had a fall on an identified date in September 2016, which resulted in an injury. The resident was transferred to hospital for further assessment and treatment of their injuries. The resident died in hospital on an identified date in October 2016.

A review of the resident's clinical records indicated that after the fall, staff conducted a fall risk assessment and an internal incident report. The fall risk assessment was used to determine the level of risk a resident was at for falls and the internal incident report was a form used for all incidents in the home involving residents, not designed specifically for falls.

It was confirmed during an interview in October 2016, with the Administrator/DOC that a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls was not conducted when

residents fell. (583)

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident (CI) inspection, log # 029284-16, conducted concurrently during this Resident Quality Inspection.

3) Resident #108 had falls on four identified dates in August 2016. A review of the resident's clinical record indicated that no post-fall assessments were conducted using a clinically appropriate assessment instrument as the home has not implemented a post-fall assessment instrument specifically designed for falls.

It was confirmed during an interview in October 2016, with the Administrator/DOC that a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls was not conducted when residents fell. (508) (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(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;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that the following is completed.

1. Develop an assessment instrument that is specifically designed for the assessment of incontinence.

2. 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.

3. Ensure that all residents receive a continence assessment using the instrument when the condition or circumstances of the resident require.

4. The home shall ensure that all registered staff receive education on their roles and responsibilities in the assessment of residents who are incontinent.

The Order is made based upon the application of the factors of severity (1 - minimal risk), scope (3 - widespread) and compliance history (4 - ongoing non-compliance with an order), and the Licensee's history of noncompliance with a VPC on March 24, 2015.

Grounds / Motifs :

1. 1. The licensee failed to ensure that when required residents were assessed using a clinically appropriate assessment instrument specifically designed for the assessment of continence.

During a family interview with resident #201's substitute decision maker (SDM) on an identified date in October 2016, it was identified resident #201 had a significant decline in their level of continence. The SDM shared they had visited the resident and observed signs of continence care needs not being met. A review of the RAI-MDS continence assessment completed on an identified date in September 2016, identified resident #201 declined from frequently incontinent to incontinent.

After a review of the resident's clinical records it was identified that a continence care assessment using a clinically appropriate assessment instrument was not completed on admission or where circumstances required. Resident #201's clinical records did not contain records that identified causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

In an interview in October 2016, with the Administrator/DOC it was confirmed that an assessment using a clinically appropriate assessment instrument specifically designed for the assessment of continence was not completed for resident #201. It was confirmed that the home did not have a clinically appropriate assessment instrument for continence developed or implemented at the time of the inspection. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The Licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The Licensee shall:

1. Provide education to all Personal Support Workers (PSW) on all equipment used for transferring and positioning residents.

2. Ensure that all new PSW staff receive mandatory education and training on the home's equipment used for transferring and positioning residents prior to operating this equipment.

Grounds / Motifs :

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

On an identified date in 2015, resident #201 was being transferred from their wheelchair to bed with two staff using a mechanical ceiling lift. During the transfer the resident slid out of the sling and fell onto the floor causing an injury.

A review of the resident's clinical record and the home's internal investigative notes revealed that the PSW did not stay to guide the resident during the transfer. The PSW was not positioned in the correct place to monitor the transfer when the bottom straps of the sling may have slipped off.

It was confirmed during an interview with the Administrator/DOC and through review of the home's documentation that the staff did not use safe transferring and positioning devices or techniques when assisting resident #201.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log #026905-15, conducted concurrently during this RQI. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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