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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Mar 15, 2017	2016_582548_0031	029893-16, 034200-16, 034291-16	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

PETER D. CLARK CENTRE
9 MERIDIAN PLACE OTTAWA ON K2G 6P8

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

RUZICA SUBOTIC-HOWELL (548), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 19, 20, 21, 22, 23, 2016 and January 3,4, 25, 26 and 27, 2017

The following logs were inspected as a part of this inspection:

029893-16, 034200-16, 034291-16 and 002210-17

complaints related to: infection prevention and control, transferring and positioning, skin and wound care, medication management, plan of care, housekeeping, retaliation and response to complaints

During the course of the inspection, the inspector(s) spoke with Substitute Decision Maker (SDM), resident, Resident Care- Manager, Personal care- Manager, Registered Nurses(RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Housekeeping staff and Trainer.

During the course of the inspection the inspectors also: observed resident care and surroundings, reviewed resident health care records, home policies, training records, video footage and photos related to resident care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 VPC(s)**
- **0 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. 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).

Findings/Faits saillants :

1. This non-compliance is related to complaint Logs #: 034200-16 and 034291-16.

The licensee has failed to ensure that the plan of care gives clear directions to staff and others who provide direct care to the resident.

Resident #001 is cognitively and physically impaired and requires total assistance for all activities of daily living.

Review of resident #001's Medication Administration Record (MAR) revealed two entries regarding eye care. The two entries in the same month provided different instructions for providing eye care.

Interviews with registered staff #104 and registered staff #101 both indicated that they had provided care as per the first entry and neither staff member were aware of the new order that provided different instructions.

Interview on December 23, 2016 with Manager, Personal care and Manager, Resident care, both indicated that the initial order should have been discontinued when the physician ordered different instructions.

Review of the physician orders for resident #001 indicated specific eye care instructions. [s. 6. (1) (c)]

2. The Licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

This non-compliance is related to complaint Log #: 034291-16

A critical incident report was submitted to the MOHLTC related to resident #001.There is video footage that was provided to the home that shows a PSW #102 use an incontinent pad that is underneath the resident to turn the resident. The incident in the report is described as the resident is being "flipped" over from the left side to the right side, in one movement by the PSW.

The SDM showed inspectors #548 and #178 video footage related to the incident. The inspectors observed one staff member use the incontinent pad that rests underneath the resident to fully turn the resident from the left side to the right side in one quick maneuver.

The health care record was reviewed.

The resident #001 requires assistance with all activities of daily living and care plan interventions for bed mobility specified that two staff are required to provide physical support to reposition the resident in bed.

On December 21, 2016 during an interview with the inspector #548 the Manager, Resident Care indicated that the PSW #100 was placed on suspension pending the conclusion of the investigation. The Manager indicated that the home perceived the incident as "not providing proper care" and "overly rough with care".

On December 23, 2016 during a phone interview the PSW #102 stated she positioned the resident on her own by using the green incontinent pad although the care plan specified that the resident requires two persons. [s. 6. (7)]

3. The Licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The non-compliance is related to complaint Log#: 34291-16.

The SDM indicated that the resident #001 was not repositioned for several hours and had raised this concern to the interdisciplinary team at a care conference the previous day.

In the resident's room there are motion activated video cameras installed by the family. On a specified day in December 2016 the SDM had indicated that the SDM had made the Administrator aware that from the review of the video footage that the resident #001 was not being repositioned every two hours at night, specifically on on two separate occasions.

The resident is dependent on staff for all activities of daily living and for repositioning. The resident's care plan has specific interventions for bed mobility: to have two staff members to reposition the resident every two hours when in bed. There is a positioning schedule that indicates the times the resident is to be positioned.

On January 3, 2017 the SDM indicated that the resident's has a routine and is to be returned to bed during a specified period of time in the evenings. On December 21, 2016 RN #100 and PSW #111 both indicated during an interview that the resident is to be repositioned every two hours during the night.

On January 3, 2016 the SDM showed the inspector #548 video footage for a specific date. The footage is time stamped and shows the resident laying on the left side in bed, an unidentified staff member is in the room with the resident. The staff member leaves the room. Approximately two hours later an unidentified staff member looks in the room, activating the camera, the resident remains in the same position. Approximately two hours later, footage shows two staff members enter the room and reposition the resident. On another evening footage shows the resident is in bed laying on his/her back. There is no activation of the video cameras until the following day in the early morning when two staff members enter the room and reposition the resident #001.

The Inspector #548 viewed the video footage for these dates and observed that the resident had not been repositioned every two hours as care planned on specific days. [s. 6. (7)]

4. The licensee has failed to ensure the provision of the care set out in the plan of care is documented.

This non-compliance is related to complaint Log #: 034291-16

The resident #001 is dependent on staff for all activities of daily living and is dependent on staff for repositioning. The resident's care plan dated has specific interventions for bed mobility: that the resident be repositioned every two hours when in bed and every hour when in a wheelchair.

On January 3, 2017 the SDM describes the resident's #001 routine is to be up out of bed between 0730 to 0800 AM and to return to bed at a few hours after lunch for a two hour rest period, then up for dinner and to be returned to bed at a specified time in the evening until the next morning. The routine was confirmed by PSW #103 and RPN #104 during an interview with inspector #548. The resident mobilizes in a wheelchair the remainder of the time.

On December 21, 2016 RN #100 and PSW #111 both indicated during an interview that the resident is to be repositioned every two hours at night. RN #100 indicated that the resident is repositioned hourly and PSW #111 indicated that the resident is repositioned at between 10 to 30 degree intervals while in a wheelchair. PSW #111 further indicated that the documentation is not consistently completed as required related to repositioning.

On a specified day in December 2016 the resident was observed by the inspector #548 to be sitting upright during breakfast service. Post breakfast the resident was observed to be tilted at approximately 20 degrees while in the wheelchair.

The home's policy indicates that Personal Support Workers, PG0207-Job Description are responsible to maintain records-flow sheets on resident's files. In relation to positioning of residents' the home requires personal support workers to record the times a resident is repositioned on a specific document titled: Repositioning Schedule (flow sheet). The schedule has a legend that prompts the PSW to record the position the resident is in, the time of repositioning and to initial. On December 22, 2016 the Manager, Personal care confirmed that PSWs are required to complete a record of the care provided to residents and on January 3, 2016 PSW #103 concurred with the manager's statement above.

The Repositioning Schedule for resident #001 was reviewed and concluded several gaps in the recording of this intervention. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the:
- plan of care provides clear direction to staff and others who provide direct care to the resident
- the care set out in the plan is provided to the resident as specified in the plan
- provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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. This non-compliance is related to complaint Log #: 029893-16.

The licensee has failed to ensure that their policy #345.3, titled: Medication Administration, was complied with in regards to the application of prescription cream to resident #001.

As per O. Reg. 79/10. S. 114 (2), the licensee is required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage and destruction and disposal of all drugs used in the home. The licensee's policy #345.3, titled: Medication Administration, dated June 2016, specifies that Registered Nurses and Registered Practical Nurses are to ensure the administration of medications.

Interviews with the SDM of resident #001 on specified days in December 2016, indicated that months previously, PSWs were applying prescription cream to resident #001.

Interview with PSW #103 on December 22, 2016 indicated that usually the registered nursing staff apply medicated creams, but sometimes when they are providing care to a resident, the registered staff will provide the PSW with the cream and they will apply it to the resident's skin. PSW #103 stated that the majority of the time the registered staff applies the medicated creams.

Interview on December 21, 2016, with registered staff #100, who works full time on resident #001's unit, indicated that in the past, PSWs applied medicated creams, but for approximately the past year, the registered staff have been applying medicated creams to residents. [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 their policy #345.3 titled: Medication Administration, is complied with in regards to the application of prescription creams for resident #001, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident equipment is kept clean and sanitary.

This non-compliance is related to complaint Logs #: 034200-16, 034291-16 and 002210-17.

This non-compliance is related to concerns expressed by resident #001's SDM that staff are not following principles of infection prevention and control (IPAC) while caring for resident #001. The resident's SDM is concerned that resident #001's wash basin is being used to wash all areas of the resident. For example, the basin will be used to provide perineal care in the evening, and then used to wash the resident's face the next morning, with no apparent sanitizing in between.

On a specified day in December 2016, Resident #001's SDM showed inspector #178 video evidence which showed staff providing perineal care for resident #001. The video showed that on a specified day in December 2016 in the early morning, two caregivers entered the resident's room to provide incontinence care. The staff members fill the resident's wash basin and use cloths to clean the resident's perineal area after removing the soiled brief. After cleaning the resident's frontal perineal area, the staff member returned the cloth to the basin of water. After the resident was re-dressed and repositioned in bed, the staff member is observed to go into the resident's washroom, empty the basin, rinse it with water only, turn it over in the resident's sink for a few seconds, and then move it to rest on top of the vanity. No solution or wipes are used to clean the basin.

Full time PSW # 103 was interviewed on December 22, 2016, regarding care of Resident #001. PSW # 103 stated that after using the basin to wash resident #001 she rinses it with hot water. She stated that staff can use Virox antibacterial wipes to clean the basin, but that she uses only hot water.

The home's Manager of Personal Care and lead for the Infection Prevention and Control program was interviewed on January 26, 2017. The Manager of Personal Care stated that currently, residents' wash basins are cleaned after each use to remove any foreign matter, but not necessarily sanitized. She stated that the home does not have a policy directing staff to disinfect or sanitize resident's basins. The home's Policy for Cleaning of Resident Care equipment (#845.01) directs that all reusable resident care equipment will be cleaned between resident usage. This Manager of Personal Care stated that resident equipment includes resident's wash basins. The policy defines clean as physically removing foreign or organic matter, and the cleaning can be done using water, soap/detergent, alcohol and friction. The Manager of Personal Care stated that at present the staff clean the basins after use using "at a minimum, water", and the staff have not been directed to do anything else, but some may use virox antibacterial wipes to clean the basins. The Manager of Personal Care stated that after researching this issue, she found that since the elderly population may be at risk for infection through fragile skin, she will be recommending that the home begin to sanitize basins on a regular basis, and document when the basins are sanitized. She is going to recommend a policy change, requiring the basins be cleaned using virox at least twice a month, as is done for residents' mobility equipment. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident equipment is kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

This non-compliance is related to complaint Logs #: 034200-16 and 034291-16.

Resident #001 requires extensive assistance in all activities of daily living. The BRADEN assessment conducted on a specified day identifies the resident as high risk for altered skin integrity.

The health care record was reviewed specific to altered skin integrity.

The resident's care plan dated specifies skin integrity interventions.

On December 23, 2016 during an interview the Manager, Resident Care indicated that redness, opening, bruising is considered an alteration in skin integrity. She further explained a wound assessment is conducted with altered skin integrity. The Wound Assessment tool specifies to document the location of the wounds, ulcer staging, length, depth, undermining/tunneling, wound document the location of the wounds, ulcer staging,

length, depth, undermining/tunneling, wound base, exudate, odour, periwound skin observation, sensation, pain, debridement, referrals, treatment and revision of care plan.

The licensee has a tool titled: Skin Assessment that is specifically designed for skin assessments for when a resident returns to the home from a leave of absence greater than 24 hours. As well, the licensee's policy titled: Assessment: Skin, policy #: 315.12, revision date: June 2012 specifies that a skin assessment is to be conducted post absence from the home and should a resident exhibit altered skin integrity that a Wound Assessment Tool be completed.

On January 4, 2017 during an interview RN #100 and RPN #110 both stated that when there is an alteration in skin integrity a wound assessment is to be conducted and this assessment could be located electronically, on the hard copy assessment tool or in the progress notes.

On a specified day in December 2016 during an interview with the inspector #548 the SDM indicated that while the resident #001 was on leave of absence the SDM observed two areas of altered skin integrity on a certain location of the resident's body that were not there previously.

The SDM indicated that the SDM called the home and spoke to a registered nursing staff member of the observation.

A progress note entry dated on a specified day from RN #100 indicated that SDM informed the RN of the area of concern. That same day the resident returned to the home and RPN # 110 documented in the progress notes her observation of the altered skin integrity.

Both RN #100 and RPN #110 indicated a wound assessment of the initial area should have been conducted.

The home was not able to produce the initial wound assessment. [s. 50. (2)(b) (i)] (548) [s. 50. (2) (b) (i)]

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 when a resident exhibits altered skin integrity that they receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participates in implementation of the infection prevention and control program, specifically the home's hand hygiene program.

This non-compliance is related to complaint Logs #: 029893-16 and 034200-16.

This non-compliance is related to concerns expressed by resident #001's SDM that staff are not following principles of infection prevention and control (IPAC) while caring for resident #001.

On a specified day in December 2016, Resident #001's SDM showed inspector #178 video evidence which the SDM felt displayed that the staff were not performing hand hygiene appropriately during care of Resident #001. The video showed that on a specified day in the early morning, two caregivers entered the resident's room wearing gloves. One caregiver is observed washing the resident's front and back perineal area, and then without changing gloves or performing hand hygiene, the staff member dresses the resident and repositions the resident in bed, including touching and positioning the pillow under the resident's head, and pulls up the resident's covers.

The home's Manager of Personal Care and lead for the Infection Prevention and Control program was interviewed on January 27, 2017. The Manager of Personal Care stated that according to the home's hand hygiene policy, if staff has provided perineal care to a resident, they should remove gloves and perform hand hygiene before dressing the resident and before repositioning the resident in bed. She stated that after providing perineal care, those gloves would be contaminated, and should be changed before continuing with the resident's care.

On December 27, 2017, Inspector #178 reviewed the home's Hand Hygiene Program, policy #825.07, last revised in August 2016. The policy states that staff will perform hand hygiene, either using alcohol based hand rub or soap and water, after bodily fluid exposure risk, including cleaning up urine or feces and handling incontinence products. The policy also states that hand hygiene will be performed between tasks for the same resident, to prevent cross contamination of different body sites. [s. 229. (4)]

2. The licensee has failed to ensure that staff participate in the infection prevention and control program, specifically with relation to the cleaning of resident equipment after use.

This non-compliance is related to concerns expressed by resident #001's SDM that staff are not following principles of infection prevention and control (IPAC) while caring for resident #001. Resident #001's SDM is concerned that resident #001's bedpan is not cleaned properly after use.

On a specified day Resident #001's SDM showed inspector #178 video evidence which the SDM felt displayed the staff not cleaning the resident's bedpan properly after use. The first video showed that on a specified day, after resident #001 used the bedpan, the caregiver rinsed the bed pan in the sink, and then placed it on the edge of the sink, approximately one foot away from the open denture cup. No soap or cleanser or antibacterial solution is used to clean the bedpan.

Video number two showed that on a specified day, after resident #001 used the bedpan, it is emptied in the toilet, then rinsed inside and out with water in the resident's bathroom sink, and then placed on top of the toilet tank. No cleanser, or soap, or antibacterial was used to clean the bedpan.

Full time PSW #103 was interviewed on a specified day in December 2016, regarding care of Resident #001. PSW # 103 stated that after the resident #001 has used the bedpan, she empties it in the toilet, and then cleans it by rinsing it with hot water two or

three times. PSW # 103 was not aware of any disinfection process used on residents' bedpans.

The home's Manager of Personal Care and lead for the Infection Prevention and Control program was interviewed on January 26, 2017. The Manager of Personal Care stated that according to the home's Policy for Cleaning of Resident Care equipment (#845.01), bedpans are to be cleaned and disinfected after each use. The Manager of Personal Care stated that bedpans are to be cleaned of any visible debris, and then cleaned using a Virox antibacterial wipe.

On January 30, 2017, the Manager for Personal Care informed inspector #178 that she is aware that not all staff are disinfecting or sanitizing bedpans with a Virox wipe or spray after use, but that it is part of the policy and the expectation of care that they do so. She stated that she is working with the staff to develop a process which will make the wipes or spray accessible to staff when they need it, while keeping the products out of residents ' hands, thereby making the staff more likely to comply with the home's policy.

Inspector #178 reviewed the policy, Cleaning of Resident Care equipment (#845.01, approval date Jan 2010, last revised/reviewed Jul 2013). The policy states that all reusable resident care equipment will be cleaned between resident usage, and that some items may require low level disinfection. According to the home's Manager of Personal Care and lead for the Infection Prevention and Control program, bedpans and urinals and commodes are items which require disinfection after cleaning. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff participates in the implementation of the infection prevention and control program, specifically with regards to:
- the home's hand hygiene program and,
- cleaning of resident equipment after use, to be implemented voluntarily.

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

Issued on this 17th day of March, 2017

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

Original report signed by the inspector.