Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2018;	2018_505103_0013 (A1)	008277-18	Resident Quality Inspection

Licensee/Titulaire de permis

Providence Care Centre
752 King Street West KINGSTON ON K7L 4X3

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

Providence Manor
275 Sydenham Street KINGSTON ON K7K 1G7

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

Amended by DARLENE MURPHY (103) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home identified five doors that require repair and parts to facilitate door security. The home requested and received an extension to the compliance date which has been amended to August 23, 2018.

Issued on this 18 day of July 2018 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2018;	2018_505103_0013 (A1)	008277-18	Resident Quality Inspection

Licensee/Titulaire de permis

Providence Care Centre
752 King Street West KINGSTON ON K7L 4X3

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

Providence Manor
275 Sydenham Street KINGSTON ON K7K 1G7

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

Amended by DARLENE MURPHY (103) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 25, 26, 27, 30, May 1, 2, 4, 7.

The following intakes were included in this inspection:

Log #026559-17- CIS #C553-000019-17-resident fall that resulted in an injury,

Log #028716-17- CIS #C553-000023-17-disease outbreak,

Log #029604-17- CIS #C553-000028-17-disease outbreak, and

Log #001557-18- CIS #C553-000030-17-resident fall that resulted in an injury.

During the course of the inspection, the inspector(s) spoke with residents, family members, Resident and Family Council Executive assistant, Family Council Chair and Vice Chair, Personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Nurse Pracitioner (NP), the Registered Dietitian (RD), Admission and Resident/Family Coordinator, Occupational Health and Safety Coordinator, the RAI Coordinator, RAI assistant, the Assistant Directors of Care, (ADOC), and the interim Director of Care (DOC).

During the course of the inspection, the inspector(s) conducted a full walking tour of the home, made observations related to resident care, medication administration, drug storage and infection, prevention and control measures, and reviewed relevant policies, resident health care records and the process for

the management of medication incidents.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Continence Care and Bowel Management

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Prevention of Abuse, Neglect and Retaliation

Residents' Council

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

- **10 WN(s)**
- **4 VPC(s)**
- **2 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

The following was observed throughout the inspection period:

April 25, 2018 during the initial tour of the home -

3rd Floor
- Clean utility room 1-3005 – door closed, but not locked,
- Eye wash station room 1-3019 – door observed ajar and could be pushed open,
- Linen Room 1-3048 – door closed, but not locked,
- Linen Room 1-3082 – door closed, but not locked,
- Tub/Shower Room 1-3124 – door closed, but not locked.

4th Floor
- Housekeeping Room 1-4006 – door closed, but not locked,
- Conference Room 1-4117 – door closed, but not locked,
- Soiled Utility Room – door observed ajar and could be pushed open,
- Housekeeping Room 1-4095 – door closed, but not locked.

5th Floor
- Linen/Clean Utility Room 1-5005 – door closed, but not locked,
- Soiled utility Room 1-5035 – door closed, but not locked,
- Supply Room 1-5048 – door closed, but not locked,
- Linen Room 1-5119 – door closed, but not locked,
- Staff Conference Room 1-5118 – door closed, but not locked.

April 27, 2018 -

- Staff Washroom 1-3020 – door closed, but not locked,
- Eye Wash Room 1-3019 – door observed ajar and could be pushed open,
- Staff Washroom 1-3062 – door observed ajar and could be pushed open.

April 30, 2018-

- Soiled Utility Room 1-4080 – door observed ajar and could be pushed open,
- Linen Room 1-3048 - door closed, but not locked,
- Supply Room 1-3050 - door closed, but not locked,
- Soiled Utility Room 1-3036 - door closed, but not locked.

May 2, 2018 –

- Linen/Clean Utility Room 1-5005 - door closed, but not locked.

May 4, 2018 –

- Housekeeping Room 1-4006 - door closed, but not locked.

All of the doors noted above were not being supervised by staff at the time of the observations. All doors referred to above were equipped with a push code lock/pad and each had a note on the door that indicated "Per the MOHLTC: All doors must be closed and locked for resident safety!"

On April 25, 2017, when the door to room 1-5035 was found closed, but not locked, Inspector #197 spoke to a member of the housekeeping staff. The housekeeping staff member indicated that the door should be locked and that staff need to punch in the code to get into the room. The housekeeping staff member proceeded to turn the knob a couple of times and was able to get the door to lock.

On April 27, 2018, Inspector #103 interviewed RPN #100 when the door to room 1-3019 was observed to be closed, but not locked. At time of observation there was one resident noted with a walker just outside of this door. Upon entering the room, it was noted to contain various cleaning supplies/chemicals. The RPN proceeded to the door and observed it unlocked as the inspector had found it. The RPN indicated the door should be locked when staff are not in the room and stated the room is used by housekeeping staff and that they would inform them about the door being left open. [s. 9. (1) 2.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's medication incidents were reviewed from January 1, 2018 to March 26, 2018. Incident #6908 involved resident #026 who was prescribed to receive an identified medication daily at 1700 hour. On an identified date, the nurse administered the prescribed dosage of the identified medication to resident #026 at 1530 hour. The nurse was notified at 1600 hour that the physician ordered the identified medication to be held. The resident's health care record and the medication incident report were reviewed. There was no documented evidence that resident #026 was assessed as a result of this error. Additionally, there was no documentation to reflect the incident was reported to the resident, or the resident's substitute decision maker.

Incident #6967 involved resident #025 who was prescribed a pain patch to be applied topically every three days and the old patch to be removed before applying the new patch. On a specified date, it was discovered the resident had missed the scheduled patch change three days earlier. The resident's health care record and the medication incident report were reviewed. There was no documented evidence that resident #025 was assessed as a result of this error. Additionally, there was no documentation to reflect the incident was reported to the resident, the resident's substitute decision maker, or the prescriber of the drug.

Incident #7681 involved resident #024 who was prescribed two pain patches of designated strengths, both to be applied topically every three days and the old patches to be removed before applying the new patches. On a specified date, it was discovered the resident had not received the scheduled patch changes due two days prior and the old patches from five days prior had not been removed. The resident's health care record and the medication incident report were reviewed. There was no documented evidence that resident #024 was assessed as a result of this error. During a review of the resident's electronic medication administration record for an identified month, it was noted the resident requested and received three doses of an identified prescribed narcotic for breakthrough pain on a

identified date that was associated with the missed application of pain patches. Additionally, there was no documentation to reflect the incident was reported to the resident, the resident's substitute decision maker, or the prescriber of the drug.

ADOC #116 was interviewed in regards to medication incidents. They indicated all assessments and notifications related to the medication incident would be documented either on the incident report or in the resident's health care record. The ADOC indicated failure to find the documentation in either of these areas would indicate they were not completed.

The licensee failed to ensure residents #026, #025 and #024 were assessed following medication incidents and failed to ensure the legislated notifications were made as a result of these medication incidents. [s. 135. (1)]

2. The licensee has failed to ensure all medication incidents were documented, reviewed and analyzed, corrective action was taken and a written record was kept.

As outlined above, medication incidents #6908, #6967 and #7681 were reviewed. The ADOC's were identified as the persons responsible for investigating the medication incidents when they are discovered. ADOC #116 was interviewed and stated upon being made aware of the incidents, the ADOC's investigate the circumstances that led up to the error, speak with the staff members responsible for the incident, and initiate the incident report. The ADOC stated the discussions held with the staff members or any corrective actions taken are not documented. [s. 135. (2)]

3. The licensee has failed to ensure a quarterly review is undertaken of all medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents, any changes and improvements identified in the review are implemented and a written record is kept of everything.

The interim DOC was interviewed and stated the home's medication incidents are reviewed at the Pharmacy and Therapeutics committee which meet on a quarterly basis. This committee is multidisciplinary and include the Medical Director, the Administrator, the DOC, Nurse practitioner, a Registered Nurse and the pharmacist. The interim DOC stated the medication incidents are broken down into categories and there is an overview of the incidents that occurred during the past quarter. The interim DOC stated many of the incidents that occurred during the

previous quarter were believed to be the result of distraction at the time of medication administration. The interim DOC was unable to outline any changes or improvements made to address this issue and stated there was no written documentation to reflect any actions taken to reduce and prevent the medication incidents. [s. 135. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following finding relates to Log #026559-17:

The licensee has failed to ensure that the care set out in the plan of care for resident #022 was provided to the resident as specified in the plan.

A Medical Resident wrote a progress note on a specified date that indicated resident #022 had frequent falls and an identified fall prevention measure would be ordered if available. The following day, Nurse Practitioner (NP) #118 wrote an order for the identified fall prevention measure to be used twenty-four hours/day, as tolerated.

Progress notes through the trial period indicated the following:
On a designated date-identified fall prevention measure applied at 1100 hour. Resident tolerated all shift.
On a designated date seven days later- identified fall prevention measure was soaked with urine. Staff unable to put back on resident.
On another designated date- RPN documented that resident #022's identified fall prevention measure was soaked in urine. The note further stated that the resident was not wearing the identified fall prevention measure at that time and that they needed more than one.

On a specified date, resident #022 fell at 0950 hours. The progress notes indicated that the resident had been incontinent in bed prior to the fall and didn't have the identified fall prevention measure on. Resident #022 was assessed and sustained a significant injury as a result of the fall.

During an interview with NP #118, they indicated that once the trial was done, if resident #022 was tolerating the identified fall prevention measure, staff were to continue to use. Inspector also discussed the home's process for cleaning and the fact that resident #022 only had one available. The NP stated two would be best, but the process was to wash on nights when necessary and keep in the resident's room to put back on in the morning.

The home did not provide the care set out in the resident's plan of care as the order indicated the resident should utilize the identified fall prevention measure twenty-four hours/day as tolerated. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the care set out in resident #022's plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The following finding relates to Log #026559-17:

The licensee has failed to ensure that supplies for the falls prevention and management program were readily available in the home.

On a specified date, Nurse Practitioner (NP) #118 wrote an order for a trial of an identified fall prevention measure for resident #022 to be used twenty-four hours each day, as tolerated.

Multiple notes were made in resident #022's medical chart after the identified fall prevention measure was ordered and indicated they were not available at certain times.

During interviews with NP #118 and the Director of Care (DOC), both indicated to the inspector that the identified fall prevention measure is a part of the falls prevention and management program.

NP #118 further told the inspector that the home does not provide the identified fall prevention measure for residents, but rather they get consent from the family who then purchase through an outside company.

The licensee has failed to ensure the identified fall prevention measure for the falls prevention and management program were readily available in the home. [s. 49. (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 the identified fall prevention measure, as a part of the falls prevention and management program, are readily available in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within ten days of receiving Family Council advice related to concerns or recommendations.

During an interview with the Family Council Vice Chair, they indicated the home does not always respond in writing to their concerns within the ten day timeline.

The Family Council meeting minutes and responses were reviewed and the following was found:

November 2017 - concerns/recommendations made to the home including a request to see an overview of a particular project, a sample form to address concerns, the frequency of resident checks during a shift, oral care for residents, communication of what staff are working on each floor, implementation of signs to remind staff and families to wash their hands, a bathroom that needs repairs.

Meeting minutes were noted to be sent to the Administrator on November 15, 2017 and the response from management was noted to come on November 28, 2017, thirteen days after the advice was submitted.

January 2018 - concerns/recommendations made to the home including how to reach RN after hours, wanting a quality improvement presentation, transportation request form, portering of residents, poor quality forms, putting up a bulletin board, infection control, satisfaction survey results, vending machines/food services, admission process, resident dining rooms, laundry machines on home areas, elevators, lost and found and volunteer recruitment.

Meeting minutes were noted to be sent to the Administrator on January 11, 2018 and the written response from the home was dated January 31, 2018, twenty days after the advice was submitted.

February 2018 - concerns/recommendations made to the home including having a hot beverage vending machine, getting family volunteers, what happens to broken items, elevators, lost and found logging system, shortage of commodes, residents being left unsupervised at nursing stations and families not being contacted in a timely manner.

Meeting minutes were noted to be sent to the Administrator on February 12, 2018 and the written response from the home was noted to come on February 23, 2018, eleven days after the advice was submitted.

For the months of November 2017, January 2018 and February 2018, the licensee did not respond to the Family Council in writing within ten days of receiving advice related to concerns or recommendations. [s. 60. (2)]

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 the Family Council receive a response from the licensee within ten days of receiving any concerns or recommendations from the Family Council, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The home's medication incidents were reviewed from January 1, 2018 to March 26, 2018. Incident #6908 involved resident #026 who was prescribed to receive an identified medication daily at 1700 hour. On an identified date, the nurse administered the prescribed dosage of the identified medication to resident #026 at 1530 hour. The nurse was notified at 1600 hour that the physician ordered the identified medication to be held.

Incident #6967 involved resident #025 who was prescribed a pain patch to be applied topically every three days and the old patch to be removed before applying the new patch. On a specified date, it was discovered the resident had missed the scheduled patch change three days earlier.

Incident #7681 involved resident #024 who was prescribed two pain patches of designated strengths, both to be applied topically every three days and the old patches to be removed before applying the new patches. On a specified date, it was discovered the resident had not received the scheduled patch changes due two days prior and the old patches from five days prior had not been removed .

There were no serious outcomes to resident #026 and #025 as a result of the medication incidents, however resident #024 required three doses of a prescribed narcotic for the management of breakthrough pain on a identified date that was associated with the missed application of pain patches.

The licensee failed to ensure residents #026, #025 and #024 were administered drugs in accordance with the directions specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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 has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg 79/10, s. 114 (2), the licensee failed to ensure the written policy to ensure the accurate dispensing of all drugs kept in the home was complied with.

Specifically, staff failed to comply with the licensee's policy regarding "Medication Administration-Narcotic Administration, #PM-CD-M-1e", which was last reviewed on December 20, 2010. This policy states, "as narcotics administered, the number of tablets will be subtracted from the total."

On May 2, 2018 on or about 0820 hour, this inspector observed the administration of medications to resident #024 by RPN #113. The resident was scheduled to receive a number of medications including an identified narcotic and an identified

benzodiazepine (both controlled substances). Upon completion of the medication administration, RPN #113 was observed signing off all of the medications on the electronic medication administration record (eMAR). The RPN indicated they had completed the medication administration for resident #024. The inspector asked if there were any additional areas to record the administration of the narcotic and benzodiazepine that were administered to the resident. The RPN stated there is an additional sheet for resident #024 for both that are in a binder kept in the medication room. RPN #113 stated these sheets are utilized at shift change to conduct the count for all controlled substances which are double locked on the medication cart. The RPN stated they do not sign off on those sheets until all of the morning medications have been given.

On May 2, 2018 on or about 1140 hour, this inspector observed a medication cart in another area of the home. RPN #114 was approached by this inspector and asked if they would give the inspector access to the medication room and observe the inspector while conducting observations related to the drug storage area. During the observation, RPN #114 stated that all narcotics and benzodiazepines are signed off on the eMAR at the time of administration and that an additional sheet is also signed that tracks the number of remaining medications. The RPN showed this inspector the binder where the sheets for each resident is kept and stated the binder is too big to keep on the medication cart. The RPN further added that these sheets are not signed for at the time of administration. RPN #114 indicated they had not yet signed off on any of the narcotics or benzodiazepines that they had administered during the 0800 hour medication pass.

The interim DOC was interviewed in regards to these observations. They stated it is expected that all of the signage is completed at the time of administration for all narcotics and controlled substances as outlined in the home's policy.

The licensee has failed to ensure the medication administration policy regarding controlled substances administration was complied with. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

During a review of the Residents' Council meeting minutes, the inspector noted a memo dated August 15, 2017 regarding the Resident and Family Survey. The memo indicated that surveyors from a particular company would be in the home over a three day period and that they would survey 100 randomly selected residents. The memo further indicated family surveys would be mailed out to 140 family members (all floors) after the resident survey has been completed.

During an interview with the Vice Chair of the Family Council, they indicated that they had asked for a copy of the family satisfaction survey and was told that this is not the home's process and that they may or may not receive a survey in the mail if they are one of the 140 families selected.

Providence Manor is a 243 bed home. The process outlined in the memo does not provide the opportunity for each resident and their families to participate in the satisfaction survey process every year. [s. 85. (1)]

2. The licensee has failed to ensure that they seek the advice of the Residents' and Family Councils in developing and carrying out of the satisfaction survey.

During an interview on May 1, 2018, the assistant to the Resident's Council indicated to the inspector that the Residents' Council has never been consulted by the licensee to give advice regarding the development and carrying out of the satisfaction survey.

The Family Council Chair and Vice-Chair were interviewed and also indicated that they had not been consulted by the licensee to give advice regarding the development and carrying out of the satisfaction survey in 2017.

The Administrator who oversaw the 2017 satisfaction survey process no longer works in the home and the current Administrator was not available for interview. The Executive Assistant to the VP/Administrator indicated to the Inspector that to their knowledge the satisfaction survey was not provided to the Resident or Family Council to provide input before being carried out. The Executive Assistant indicated the home uses NRC Picker Canada to complete the survey and they stated they have five questions they can add. The Executive Assistant stated that in 2017 the home did not add the five questions and went with the standard survey.

The licensee did not seek the advice of the Residents' or Family Councils advice in developing and carrying out the satisfaction survey in the home. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The following finding relates to Logs #028716-17 and #029604-17:

The licensee has failed to ensure the Director (MOHLTC) was immediately informed of an outbreak of a reportable disease or communicable disease.

On an identified date, twelve residents presented with symptoms that included nausea, vomiting and diarrhea. The public health unit (PHU) was notified the same day and declared an enteric outbreak in the home. A critical incident (#C553-000023-17) was submitted to the MOHLTC three days later to report the outbreak.

On an identified date, two residents presented with symptoms consistent with an acute respiratory illness (ARI). The PHU was notified the same day and an ARI outbreak was declared on December 21, 2017. A critical incident (#C553-000028-17) was submitted to the MOHLTC two days later.

In a discussion with the Interim DOC, she acknowledged the critical incidents were the means by which the MOHLTC were notified of the outbreaks.

The licensee failed to ensure the Director (MOHLTC) was immediately informed of outbreaks of a reportable disease or communicable disease. [s. 107. (1) 5.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the admission package provided to every resident and to the substitute decision maker at the time of the resident admission included information related to the resident's obligation to pay accommodation charges during a medical, psychiatric, vacation or casual absence.

The licensee was provided with a copy of the "Admission Process confirmation checklist" as a part of the Resident Quality Inspection process. The home completed the checklist and indicated the current admission package did not contain a statement that outlined the obligation of a resident to pay accommodation charges during a medical, psychiatric, vacation or casual leave.

The Admissions and Resident/Family coordinator #117 was interviewed and reviewed the admission package with inspector #103. There was no evidence of this information being included in the package. [s. 224. (1) 3.]

Issued on this 18 day of July 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by DARLENE MURPHY (103) - (A1)

Inspection No. / No de l'inspection : 2018_505103_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 008277-18 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 18, 2018;(A1)

Licensee / Titulaire de permis : Providence Care Centre
752 King Street West, KINGSTON, ON, K7L-4X3

LTC Home / Foyer de SLD : Providence Manor
275 Sydenham Street, KINGSTON, ON, K7K-1G7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Paul O'Krafka

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

To Providence Care Centre, 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 :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and

   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 9 (1) 2.

Specifically, the licensee must ensure doors #1-3005, #1-3019, #1-3020, #1-3036, #1-3048, #1-3050, #1-3062, #1-3082, #1-3124, #1-4006, #1-4117, #1-4080, #1-4095, #1-5005, #1-5035, #1-5048, #1-5119, #1-5118 and any other doors leading to non residential areas are kept closed and locked when not supervised by staff.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

The following was observed throughout the inspection period:

April 25, 2018 during the initial tour of the home -

3rd Floor
- Clean utility room 1-3005 – door closed, but not locked,
- Eye wash station room 1-3019 – door observed ajar and could be pushed open,
- Linen Room 1-3048 – door closed, but not locked,
- Linen Room 1-3082 – door closed, but not locked,
- Tub/Shower Room 1-3124 – door closed, but not locked.

4th Floor
- Housekeeping Room 1-4006 – door closed, but not locked,
- Conference Room 1-4117 – door closed, but not locked,
- Soiled Utility Room – door observed ajar and could be pushed open,
- Housekeeping Room 1-4095 – door closed, but not locked.

5th Floor
- Linen/Clean Utility Room 1-5005 – door closed, but not locked,
- Soiled utility Room 1-5035 – door closed, but not locked,
- Supply Room 1-5048 – door closed, but not locked,
- Linen Room 1-5119 – door closed, but not locked,
- Staff Conference Room 1-5118 – door closed, but not locked.

April 27, 2018 -

- Staff Washroom 1-3020 – door closed, but not locked,
- Eye Wash Room 1-3019 – door observed ajar and could be pushed open.
- Staff Washroom 1-3062 – door observed ajar and could be pushed open.

April 30, 2018-

- Soiled Utility Room 1-4080 – door observed ajar and could be pushed open,
- Linen Room 1-3048 - door closed, but not locked,
- Supply Room 1-3050 - door closed, but not locked,
- Soiled Utility Room 1-3036 - door closed, but not locked.

May 2, 2018 –

- Linen/Clean Utility Room 1-5005 - door closed, but not locked.

May 4, 2018 –

- Housekeeping Room 1-4006 - door closed, but not locked.

All of the doors noted above were not being supervised by staff at the time of the observations. All doors referred to above were equipped with a push code lock/pad and each had a note on the door that indicated "Per the MOHLTC: All doors must be closed and locked for resident safety!"

On April 25, 2017, when the door to room 1-5035 was found closed, but not locked, Inspector #197 spoke to a member of the housekeeping staff. The housekeeping staff member indicated that the door should be locked and that staff need to punch in the code to get into the room. The housekeeping staff member proceeded to turn the knob a couple of times and was able to get the door to lock.

On April 27, 2018, Inspector #103 interviewed RPN #100 when the door to room 1-3019 was observed to be closed, but not locked. At time of observation there was one resident noted with a walker just outside of this door. Upon entering the room, it was noted to contain various cleaning supplies/chemicals. The RPN proceeded to

the door and observed it unlocked as the inspector had found it. The RPN indicated the door should be locked when staff are not in the room and stated the room is used by housekeeping staff and that they would inform them about the door being left open.

Discussion was held with the interim DOC who stated the staff are expected to ensure all doors leading to non residential areas are closed and locked when staff are not present.

The decision to issue this non-compliance as an order was based on the following:
The severity of this issue was determined to be a level two (minimum harm or potential for actual harm).
The scope of this issue was determined to be a level two (pattern) as the non-compliance occurred on three different floors and were found on more than one inspection day.
The home had a level four compliance history of on-going non-compliance with this section of the Regulations that included:
-Written Notification (WN) issued November 30, 2015 (2015_444602_0034), and
-WN and Voluntary plan of correction (VPC) issued September 18, 2017 (2017_520622_0032).
(103) (197)

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

Aug 23, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 135 (1).

Specifically, the licensee must ensure:
- every medication incident involving residents #026, #025 and #024 and any additional residents are documented together with a record of the immediate actions taken to assess and maintain the resident's health, and
-every medication incident involving residents #026, #025 and #024 and any additional residents are reported to the resident, resident's substitute decision-maker, if any, the prescriber of the drug, and the resident's attending physician or the registered nurse in the extended class attending the resident.

Grounds / Motifs :

1. The licensee has failed to ensure every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's medication incidents were reviewed from January 1, 2018 to March 26, 2018. Incident #6908 involved resident #026 who was prescribed to receive an identified medication daily at 1700 hour. On an identified date, the nurse administered the prescribed dosage of the identified medication to resident #026 at 1530 hour. The nurse was notified at 1600 hour that the physician had ordered the identified medication to be held. The resident's health care record and the medication incident report were reviewed. There was no documented evidence that resident #026 was assessed as a result of this error. Additionally, there was no documentation to reflect the incident was reported to the resident, or the resident's substitute decision maker.

Incident #6967 involved resident #025 who was prescribed a pain patch to be applied topically every three days and the old patch to be removed before applying the new patch. On a specified date, it was discovered the resident had missed the scheduled patch change three days earlier. The resident's health care record and the medication incident report were reviewed. There was no documented evidence that resident #025 was assessed as a result of this error. Additionally, there was no documentation to reflect the incident was reported to the resident, the resident's substitute decision maker, or the prescriber of the drug.

Incident #7681 involved resident #024 who was prescribed two pain patches of designated strengths, both to be applied topically every three days and the old patches to be removed before applying the new patches. On a specified date, it was discovered the resident had not received the scheduled patch changes due two days prior and the old patches from five days prior had not been removed. The resident's health care record and the medication incident report were reviewed. There was no documented evidence that resident #024 was assessed as a result of this error. During a review of the resident's electronic medication administration record for an identified month, it was noted the resident requested and received three doses of an identified prescribed narcotic for breakthrough pain on a identified date that was associated with the missed application of pain patches. Additionally, there was no documentation to reflect the incident was reported to the resident, the resident's substitute decision maker, or the prescriber of the drug.

ADOC #116 was interviewed in regards to medication incidents. They indicated all assessments and notifications related to the medication incident would be documented either on the incident report or in the resident's health care record. The ADOC indicated failure to find the documentation in either of these areas would

indicate they were not completed.

The licensee failed to ensure residents #026, #025 and #024 were assessed following medication incidents and failed to ensure the legislated notifications were made as a result of these medication incidents. [s. 135. (1)]

The decision to issue this non-compliance as a compliance order was based on the following:
The severity of this issue was a level 3 (actual harm) as resident #024 required breakthrough medication to be administered three times in one day when the regularly scheduled identified pain patches had not been applied.
The scope of this issue was determined to be a level two (pattern) as incidents involving the identified pain patches occurred involving two out of the three incidents reviewed.
The home had a level three compliance history of on-going non-compliance with this section of the Regulations that included:
-Written Notification (WN) and Voluntary Plan of Correction (VPC) issued September 18, 2017 (2017_520622_0032).
(103)

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

Jun 15, 2018

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18 day of July 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by DARLENE MURPHY - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Ottawa