Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 16, 2020	2020_725522_0001	003591-20	Critical Incident System

Licensee/Titulaire de permis

The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's
643 West Gore Street STRATFORD ON N5A 1L4

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

Spruce Lodge Home for the Aged
643 West Gore Street STRATFORD ON N5A 1L4

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

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 5, 6, 9, 10, 11, and May 12, 14, 19, 20, 21, and 26, 2020.

During this inspection Critical Incident System (CIS) report #M575-000008-20/Log #003591-20 related to falls prevention was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Assistant Director of Resident Care, the Resident Assessment Instrument (RAI) Coordinator, the Quality Coordinator, the Therapy Coordinator, the Human Resources Coordinator, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, a Occupational Therapy Aide/Physiotherapy Aide and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 VPC(s)**
- **1 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	Légende 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. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A) A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the fall of resident #001.

Review of the CIS noted on a specific date, resident #001 had a fall with injury.

The CIS further noted that the Registered Practical Nurse (RPN) who responded to the fall observed resident #001's assistive device and noted a support piece had not been applied appropriately.

Review of the manufacturer's instructions for the assistive device noted the support piece had not been applied as per the manufacturer's instructions.

In an interview, Personal Support Worker (PSW) #105 stated they were present when resident #001 fell. PSW #105 stated the contributing factor to resident #001's fall was that the support piece had not been applied appropriately to resident #001's assistive device.

In an interview RPN #106 stated they responded to resident #001's fall. RPN #106 stated the contributing factor to the fall was that the support piece had not been applied appropriately to resident #001's assistive device.

In an interview, Assistant Director of Resident Care (ADRC) #100 stated they had met with staff related to resident #001's fall. ADRC #100 stated the support piece had not been applied appropriately to resident #001's assistive device. ADRC #100 stated when PSW staff transferred resident #001, PSW staff did not check that the support piece had been applied appropriately to resident #001's assistive device.

ADRC #100 stated they would expect as part of safety checks that PSW staff would check that the support piece had been applied appropriately to resident #001's assistive device.

B) On a specific date, resident #001 was observed with a Personal Assistance Services Device (PASD) in place. The PASD had not been applied appropriately.

Inspector #522 went immediately to get Registered Nurse (RN) #101 to inform them. RN #101 observed resident #001's PASD. RN #101 stated resident #001's PASD had not been applied appropriately.

In an interview, Therapy Coordinator (TC) #102 stated that resident #001 used a specific type of PASD.

Review of the manufacturer's instructions for the specific type of PASD noted the PASD had not been applied as per the manufacturer's instructions.

In an interview, Personal Support Worker (PSW) #111 stated they had received training on the minimizing of restraining, but it had been awhile.

In an interview, Human Resources (HR) Coordinator #112 stated training for the minimizing of restraining was completed annually online on In Touch Link. HR Coordinator #112 provided inspector with staff training records for the minimizing of restraining.

Review of the staff training records with HR Coordinator #112 noted that staff had not received training for the minimizing of restraining in 2019. HR Coordinator #112 confirmed that staff training records indicated that staff had not completed training for the minimizing of restraining since 2017.

C) On a specific date, resident #005 was observed with a PASD in place. The PASD was not applied appropriately.

Resident #005 stated they were able to apply the PASD on their own. PSW #108 stated that they had assisted resident #005 to apply the PASD and that it was normal for resident #005 to have the PASD applied that way.

Inspector went to Therapy Coordinator (TC) #102 and asked the TC to observe resident #005. TC #102 observed resident #005 and stated their PASD was not applied appropriately. TC #102 reapplied the PASD appropriately.

In an interview, TC #102 stated that resident #005 used a specific type of PASD.

Review of the manufacturer's instructions for the specific type of PASD noted the PASD had not been applied as per the manufacturer's instructions.

In an interview, Assistant Director of Resident Care (ADRC) #100 stated that when staff applied the PASD they should ensure it is applied appropriately.

The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. [s. 23.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

In an interview, Registered Nurse (RN) #101 stated resident #008 had a recent fall and sustained an area of altered skin integrity.

Review of resident #008's electronic progress notes in Point Click Care (PCC) noted resident #008 sustained several areas of altered skin integrity from their fall.

Review of resident #008's electronic Treatment Administration Record (eTAR) noted no documentation related to treatments of resident #008's areas of altered skin integrity.

Review of resident #008's electronic care plan for a specific time frame noted a focus related to altered skin integrity.

In an interview along with Assistant Director of Resident Care (ADRC) #100, RN #101 stated the staff member who completed the falls assessment for a resident needed to complete the skin and wound assessment, then an eTAR would be created for the treatment of the altered skin integrity.

Inspector reviewed resident #008's eTAR and care plan with ADRC #100 and RN #101.

RN #101 stated resident #008's eTAR should have noted the treatment for resident #008's altered skin integrity and it did not.

The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident.

A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the fall of resident #001.

Review of the CIS noted on a specific date, resident #001 had a fall with injury.

On a specific date, resident #001 was observed with a Personal Assistance Services Device (PASD) in place.

In interviews, Personal Support Worker (PSW) #103 and PSW #104 both stated that after resident #001 had their fall a new intervention of using the PASD had been initiated.

On a specific date, resident #001 was observed in their room without the PASD in place.

In an interview, PSW #103 stated that resident #001 should have the PASD applied and that resident #001 must have removed the PASD. PSW #103 then applied the PASD to resident #001.

PSW #103 stated information regarding resident #001's PASD would be on resident #001's kardex which was posted in resident #001's bathroom. PSW and inspector reviewed resident #001's kardex. PSW #103 confirmed the use of the PASD was not on resident #001's kardex. PSW #103 stated that resident #001's kardex must not have been updated yet.

In an interview, PSW #105 stated they were present when resident #001 fell. PSW #105 admitted that they were worried resident #001 would fall again and applied the PASD to resident #001. PSW #105 stated they thought that they had told registered staff they had applied the PASD.

In an interview, Registered Nurse (RN) #101 stated resident #001 did not use the specific PASD and they were not aware of an order for the use of the specific PASD. RN #101 reviewed resident #001's progress notes and stated the only documentation was related to discussion about resident #001 having a different type of PASD. RN #101 reviewed the consents for resident #001 and stated the family did not sign consent for the use of the PASD and that there were no doctor's orders. RN #101 stated that PSWs should not be applying the PASD to resident #001.

Later the same day, RN #101 stated the PSW that had found the resident after their fall had applied the PASD to resident #001 as they were worried about the resident's safety. RN #101 stated the PSW had been told that there was a process for applying PASDs on residents. RN #101 stated the PASD had been moved and it was not to be used.

On a specific date, observation of resident #001 noted the resident had an assistive device in place.

Review of resident #001's care plan noted it had recently been revised to include the use of an assistive device for falls prevention. The care plan indicated the device did not restrict resident #001's movement.

In an interview, RN #101 stated resident #001 used the assistive device as a PASD for

falls prevention.

In an interview, Resident Assessment Instrument Coordinator (RAI-C) #113 stated resident #001's assistive device was considered a PASD and did not have any restraining qualities.

Review of resident #001's clinical record in PCC and hard copy chart noted no assessment of resident #001 for the use of the assistive device as a PASD.

Review of resident #001's hard copy chart noted a Spruce Lodge – Consent For Use of Restraint/PASD Device(s) which indicated the device resident #001 used a specific PASD.

In an interview, ADRC #100, stated staff used a restraints checklist and the home's restraint policy described when a specific assistive device was considered a restraint or a PASD. When asked by inspector how staff determined if the assistive device was a restraint, a PASD with restraining qualities or a PASD, ADRC #100 stated that would be included in the resident's care plan.

In an interview, along with ADRC #100, RAI-C #113 stated if a specific assistive device was a restraint, PASD, or PASD with restraining qualities was on the Spruce Lodge – Consent For Use of Restraint/PASD Device(s). RAI-C #113 stated if a resident could release release the assistive device or a resident was nonambulatory then it was a PASD or if the assistive device prevented a resident from getting up then it was a restraint.

When asked by inspector if there was an assessment completed of resident #001 for the use of the PASD, RAI-C #113 stated staff would check off the appropriate box on the Consent form and then the consent was reviewed annually.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident. [s. 6. (2)]

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

On a specific date, resident #001 was observed with an assistive device in place.

In an interview, RN #101 stated that resident #001 now used the assistive device as a

PASD to prevent resident #001 from falling.

Review of resident #001's plan of care noted resident #001 used the assistive device as a PASD for falls prevention.

Review of resident #001's Point of Care (POC) documentation noted no task/intervention or related documentation related to the application of the assistive device as a PASD for resident #001.

In an interview, Personal Support Worker (PSW) #111 stated they would document the use of a PASD on POC for a resident. PSW #111 showed inspector resident #001's POC where it stated under the task "Hourly Rounding" that staff were to check that resident #001's PASD was applied appropriately.

In an interview, when asked by inspector where staff would document the application of a PASD, Therapy Coordinator (TC) #102 stated RAI-C #113 had recently added as part of the hourly checks on POC tasks for all residents that used an assistive device whether it was a restraint or PASD.

TC #102 reviewed resident #001's tasks in POC with inspector. TC #102 acknowledged there was no task related to the application of an assistive device as a PASD.

In an interview, RAI-C #113 stated that hourly rounding was part of PSW tasks for every resident, so staff were monitoring residents and checking things like call bells and PASDs in place at that time. RAI-C #113 stated they had recently added to the hourly rounding that staff were to check a resident's assistive device to ensure it was applied appropriately as part of their hourly rounding. RAI-C #113 stated whether the resident had a PASD or restraint it would be checked hourly.

In an interview, Assistant Director of Resident Care (ADRC) #100 stated PSWs would document the application of a PASD in POC. ADRC #100 stated PSWs would document in POC what was included in a resident's care plan. ADRC #100 reviewed resident #001's POC tasks and documentation and acknowledged there was no task or documentation related to the application of the assistive device as a PASD for resident #001. ADRC #100 stated under "Hourly Rounding" it indicated that staff were to check that resident #001's assistive device was applied appropriately.

The licensee has failed to ensure that the provision of the care set out in the plan of care

was documented. [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; the care set out in the plan of care is based on an assessment of the resident; and the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10 s. 30 (1) 1 states, “Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk

and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Ontario Regulation 79/10 s. 48 (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

A) A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Long-Term Care on related to the fall of resident #001.

Review of the CIS noted on a specific date, resident #001 had a fall resulting in altered skin integrity.

Review of the home's "Head Injury" policy #RCM 2-1-1 with a revision date of June 20, 2017, noted the following:

"When a resident has fallen (witnessed or unwitnessed) the R.A. staff will immediately notify the registered staff."
"Registered Staff: If the resident is verbally able to communicate having hit their head, or if the resident is cognitively impaired, and it is not able to be reliably determined, the Registered Staff will initiate a Head Injury Routine (HIR)."

"Head Injury Routine:
Take all vitals, assess pupil reaction and size, orientation and limb movement.
Observe and record vital signs as follows on Head Injury Routine Form.
1. Initial Exam
2. Hourly x 4
3. If vital signs stable continue with step 5 or 6
4. If vital signs not stable continue every 4 hours for 20 hours
5. Then every shift times 24 hours, if improvement noted
6. OR more frequently as determined by medical condition or physician order
7. All residents with actual or suspected head injury must be wakened to complete Neurological Vital Signs and chart on the HIR Form."

Review of resident #001's hard copy chart noted a Spruce Lodge Head Injury Routine Form initiated after resident #001's fall.

Review of the HIR form noted the HIR was initiated after resident #001's fall. The next HIR was completed three hours and 15 minutes after the initial assessment. Further review of the assessment noted "not available, resting" was entered under best motor response, arms and legs movement, pupil size and reaction.

The assessment for the following day, on the evening shift was absent.

In an interview, Registered Practical Nurse (RPN) #106 stated resident #001 had received medical attention after their fall and therefore the RPN did not complete the HIR every hour until the end of their shift. RPN #106 stated they had completed a baseline HIR for resident #001 and then the next HIR was completed by the night shift. RPN #106 reviewed resident #001's HIR form and acknowledged they had not completed a HIR for resident #001 the following day, on the evening shift, when it was due.

In an interview, Registered Nurse (RN) #101 stated that a HIR should be initiated after a fall or hit to the head and then completed hourly four times and then if the resident was stable they would complete the HIR every shift for 24 hours. RN #101 stated if the resident was not stable registered staff would complete the HIR every four hours for 20 hours. RN #101 stated resident #001 should have had a HIR completed even after medical attention.

RN #101 reviewed resident #001's HIR with Inspector. RN #101 stated that resident #001 should have had an initial HIR completed and then it should have been completed every hour for four hours. RN #101 acknowledged that resident's HIR had not been completed as per the HIR guidelines. Inspector asked if it was normal for registered staff to enter "not available, resting" on a HIR. RN #101 stated that was not an acceptable response and registered staff should have completed the resident's motor response, limb movement, pupil size and reaction.

RN #101 stated it was important to keep a close eye on resident #001 and ensure the HIR was completed in full and at the required time frames.

In an interview, Assistant Director of Resident Care (ADRC) #100 stated they expected resident #001 to have an initial HIR and then checked hourly for four hours. ADRC #100 stated when a HIR was done staff should wake a resident up and complete the full HIR assessment.

B) Review of the home's 72 hour nursing report noted resident #006 had an unwitnessed

fall on a specific date.

Review of resident #006's electronic progress notes in Point Click Care (PCC) noted a HIR had been initiated after the fall.

Review of resident #006's hard copy chart noted a Spruce Lodge Head Injury Routine Form.

Review of resident #006's HIR form for a specific dated and time, noted resident #006 was sleeping, was easily roused and only vitals were completed.

Review of resident #006's HIR form at another specific date and time noted the HIR had not been completed in full.

In an interview, RN #101 stated that a HIR should be initiated after a fall or hit to the head and then completed hourly four times and then if the resident was stable they would complete the HIR every shift for 24 hours. RN #101 stated if the resident was not stable registered staff would complete the HIR every four hours for 20 hours.

RN #101 reviewed resident #006's HIR with Inspector. RN #101 stated that sleeping was not an acceptable response and registered staff should have completed resident #006's HIR assessment in full.

C) Review of the home's 72 hour nursing report noted resident #007 had an unwitnessed fall on a specific date.

Review of resident #007's electronic progress notes in PCC noted a HIR had been initiated after the fall.

Review of resident #007's hard copy chart noted a Spruce Lodge Head Injury Routine Form with no month and year documented.

Review of resident #007's HIR form noted the initial and following assessment was noted on a specific day and time. The next assessment did not note the day and time completed.

In an interview, RN #101 reviewed resident #007's HIR routine and confirmed that the month and year were not on the HIR form and that date and time was missing from one

of the assessments. RN #101 stated the month, year, day and time should be on resident #007's HIR form and it should be completed hourly for the first four hours.

In an interview, Assistant Director of Resident Care (ADRC) #100 stated they expected when a HIR was completed staff should wake a resident up and complete the full HIR assessment.

The licensee has failed to ensure that the home's "Head Injury" policy was complied with. [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 the home's Falls Prevention Program policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect of each of the interdisciplinary programs required under section 48 of this Regulation: The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Ontario Regulation 79/10 s. 48. (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

In an interview, Administrator # 110 stated that the Director of Resident Care (DRC) and

Assistant Director of Resident Care (ADRC) were responsible to complete the annual evaluations of the home's required programs.

In a telephone interview, along with ADRC #100, Resident Assessment Instrument Coordinator (RAI-C) #113 stated Mandatory Program meetings were held quarterly and registered staff completed audits monthly of falls, and skin and wound.

When asked by inspector if the home completed annual evaluations of the falls prevention program and skin and wound program, RAI-C #113 stated falls and skin and wound was discussed at every Mandatory Program meeting. RAI-C #113 stated they guessed the last meeting in October 2019, could be considered the evaluation of the programs.

Review of meeting minutes of the Mandatory Program Committee dated October 10, 2019, noted no reference to the annual evaluation of the falls prevention program or skin and wound program.

Director of Resident Care (DRC) #114 provided inspector with the Falls Prevention and Skin and Wound Program evaluations for 2019.

Review of the Falls Prevention and Skin and Wound Program 2019 evaluations dated May 15, 2020, noted the evaluations were "based on the minutes of the Mandatory Program Committee 2019-20."

In a telephone interview, Quality Coordinator (QC) #115 stated that they had documented the skin and wound and falls prevention program evaluation on May 15, 2020. QC #115 stated that a formal evaluation of the programs had not taken place rather they had pulled the information from the 2019 Mandatory Program Committee meeting minutes.

In a telephone interview, DRC #114 confirmed that the evaluation that was prepared by QC #115 dated May 15, 2020, was not a formal evaluation of the Falls Prevention and Skin and Wound Program and rather was a summary of the Mandatory Program meeting minutes from 2019.

The licensee has failed to ensure that the following was complied with in respect of each of the interdisciplinary programs required under section 48 of this Regulation: The program must be evaluated and updated at least annually in accordance with evidence-

based practices and, if there were none, in accordance with prevailing practices. [s. 30. (1) 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 interdisciplinary programs required under section 48 of Ontario Regulation 79/10 are evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #5: 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 has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Long-Term Care on a specific date, related to the fall of resident #001.

Review of the CIS noted resident #001 had a fall and sustained an area of altered skin integrity.

On a specific date, resident #001 was observed with an area of altered skin integrity.

Review of resident #001’s electronic progress notes in Point Click Care (PCC) noted documentation of the area of altered skin integrity after the resident’s fall.

Review of resident #001’s electronic chart noted the absence of a skin and wound assessment regarding the area of altered skin integrity.

In an interview, Registered Practical Nurse (RPN) #106 stated they had received resident #001 after their fall and assessed the area of altered skin integrity.

In an interview along with Assistant Director of Resident Care (ADRC) #100, Registered Nurse (RN) #101 stated that when resident #001 sustained the area of altered skin integrity, a skin and wound note would be entered under the resident’s progress notes. RN #101 stated a skin assessment would not be completed for the area of altered skin integrity.

In an interview, ADRC #100 reviewed resident #001’s progress notes and assessment tab and noted a skin and wound assessment was not completed and there was no skin and wound note for resident’s area of altered skin integrity.

B) Review of the home’s 72 hour nursing report in PCC noted resident #006 had an unwitnessed fall on on a specific date, which resulted in altered skin integrity.

Review of resident #006’s electronic progress notes in PCC noted documentation related to the area of altered skin integrity.

Review of resident #006's assessment tab in PCC noted no skin and wound assessment of the area of altered skin integrity.

In an interview along with ADRC #100, RN #101 stated the initial skin assessment for

resident #006 would be the incident note and a skin and wound note in resident #006's progress notes.

RN #101 stated an assessment tool was not always completed for skin and wound issues. RN #101 stated if a resident had a skin and wound issue the Personal Support Worker would notify the Registered Practical Nurse (RPN) through their dashboard in PCC and the RPN would follow up with the resident and then judge if they needed to complete a skin and wound assessment. RN #101 acknowledged that there were no measurements or description of the area of altered skin integrity. RN #101 stated if a resident had a large area of specific altered skin integrity, registered staff would complete measurements and if a resident had a small area of specific altered skin integrity that only required a band aid registered staff would not complete measurements.

In an interview, ADRC #100 stated anytime that someone had a fall with an area of altered skin integrity a skin and wound assessment should be completed.

C) In an interview, RN #101 stated resident #008 had a recent fall and sustained an area of altered skin integrity.

Review of resident #008's electronic progress notes in PCC noted resident #008 sustained several areas of altered skin integrity after their fall.

Review of resident #008's assessment tab in PCC noted an assessment of one area of altered skin integrity.

There were no other skin assessments noted related to the additional areas of altered skin integrity resident #008 sustained from their fall.

In an interview along with ADRC #100, RN #101 stated the staff member who completed the falls assessment for a resident needed to complete the skin and wound assessment, then an eTAR would be created for area of altered skin integrity and treatment.

In an interview, ADRC #100 reviewed resident #008's assessment tab in PCC and noted a skin and wound assessment was not completed when resident #008 had a fall and sustained several areas of altered skin integrity. ADRC #100 stated anytime that someone had a fall and sustained an area of altered skin integrity a skin and wound assessment should be completed.

The licensee has failed to ensure that residents #001, #006 and #008 who exhibited areas of altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [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 a resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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, to be implemented voluntarily.

WN #6: 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, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: How to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations.

Ontario Regulation 79/10 s. 221. (2) 1 states, " The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act."

In an interview, Personal Support Worker (PSW) #111 stated they had received training on the minimizing of restraining, but it had been awhile.

In an interview, Human Resources (HR) Coordinator #112 stated training for the minimizing of restraining was completed annually online on In Touch Link. HR Coordinator #112 provided inspector with staff training records for the minimizing of restraining.

Review of the staff training records with HR Coordinator #112 noted that staff had not received training for the minimizing of restraining in 2019. HR Coordinator #112 confirmed that staff training records indicated that staff had not completed training for the minimizing of restraining since 2017.

On March 10, 2020, in an interview, Assistant Director of Resident Care (ADRC) #100 stated that the minimizing of restraining training should have been completed annually.

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 training on how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations. [s. 76. (7) 4.]

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, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: Any other areas provided for in the regulations.

A) Ontario Regulation 79/10 s. 221. (1) 1 states, "For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be

provided to all staff who provide direct care to residents: Falls prevention and management."

Ontario Regulation 79/10 s. 221. (2) 1 states, "The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act."

In an interview, PSW #111 stated they had received training on falls prevention but could not recall when they last received the training.

In an interview, HR Coordinator #112 stated training for falls prevention was completed annually online on In Touch Link. HR Coordinator provided inspector with staff training records on falls prevention.

Review of the staff training records with HR Coordinator #112 noted that staff had not received training on falls prevention in 2019. HR Coordinator #112 confirmed that staff training records indicated that staff had not completed training on falls prevention since 2017. HR Coordinator #112 stated only new hires had received falls prevention training.

In an interview, ADRC #100 stated that falls prevention training should have been completed annually.

B) Ontario Regulation 79/10 s. 221. (1) 2 states, "For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: Skin and wound care."

In an interview, Registered Nurse (RN) #101 stated they had received training from RNAO for best practice for skin and wound and that not all registered staff had received skin and wound training.

Review of the staff training records with HR Coordinator #112 noted there were no records of skin and wound training for staff in 2019. HR Coordinator #112 stated they did not have records of skin and wound training for 2019 as staff would have completed an in-service for skin and wound care.

In an interview, ADRC #100 stated they would need to look for hard copy records for skin and wound in-services for 2019.

In a telephone interview, Director of Resident Care (DRC) #114 stated that their medical supplier had completed quarterly in-services on skin and wound care with registered staff and Personal Support Workers (PSWs) in 2019.

DRC #114 stated they had kept records from the in-services on March 28, 2019, but had not kept any further records for the remaining in-services. A review of the skin and wound care training records noted indicated 11 registered staff and 12 PSWs had completed training in 2019.

DRC #114 acknowledged that all direct care staff were to have training in skin and wound care and they did not have records to verify that all direct care staff had received training in skin and wound care in 2019.

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 training in falls prevention and skin and wound care. [s. 76. (7) 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 that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training on falls prevention, skin and wound care, and how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations, to be implemented voluntarily.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Issued on this 17th day of June, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l’inspection :	2020_725522_0001
Log No. / No de registre :	003591-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 16, 2020
Licensee / Titulaire de permis :	The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's 643 West Gore Street, STRATFORD, ON, N5A-1L4
LTC Home / Foyer de SLD :	Spruce Lodge Home for the Aged 643 West Gore Street, STRATFORD, ON, N5A-1L4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Peter Bolland

Ontario

Ministry of Long-Term Care

Ministère 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 The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee must comply with s.23 of Ontario Regulation 79/10.

Specifically the licensee must ensure:
a) Staff apply assistive devices to residents #001 and #005 and any other resident in accordance with any manufacturer's instructions;
b) Staff apply the support piece to resident #001 and any other resident's assistive device in accordance with any manufacturer's instructions;
c) All direct care staff receive hands on training on the application of assistive devices;
d) Records of the training and attendees must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A) A Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Long-Term Care related to the fall of resident #001.

Review of the CIS noted on a specific date, resident #001 had a fall with injury.

The CIS further noted that the Registered Practical Nurse (RPN) who responded to the fall observed resident #001's assistive device and noted a support piece had not been applied appropriately.

Review of the manufacturer's instructions for the assistive device noted the support piece had not been applied as per the manufacturer's instructions.

In an interview, Personal Support Worker (PSW) #105 stated they were present when resident #001 fell. PSW #105 stated the contributing factor to resident #001's fall was that the support piece had not been applied appropriately to resident #001's assistive device.

In an interview RPN #106 stated they responded to resident #001's fall. RPN #106 stated the contributing factor to the fall was that the support piece had not been applied appropriately to resident #001's assistive device.

In an interview, Assistant Director of Resident Care (ADRC) #100 stated they had met with staff related to resident #001's fall. ADRC #100 stated the support piece had not been applied appropriately to resident #001's assistive device. ADRC #100 stated when PSW staff transferred resident #001, PSW staff did not check that the support piece had been applied appropriately to resident #001's assistive device.

ADRC #100 stated they would expect as part of safety checks that PSW staff would check that the support piece had been applied appropriately to resident #001's assistive device.

B) On a specific date, resident #001 was observed with a Personal Assistance Services Device (PASD) in place. The PASD had not been applied appropriately.

Inspector #522 went immediately to get Registered Nurse (RN) #101 to inform them. RN #101 observed resident #001's PASD. RN #101 stated resident #001's PASD had not been applied appropriately.

In an interview, Therapy Coordinator (TC) #102 stated that resident #001 used a specific type of PASD.

Review of the manufacturer's instructions for the specific type of PASD noted the PASD had not been applied as per the manufacturer's instructions.

In an interview, Personal Support Worker (PSW) #111 stated they had received training on the minimizing of restraining, but it had been awhile.

In an interview, Human Resources (HR) Coordinator #112 stated training for the minimizing of restraining was completed annually online on In Touch Link. HR Coordinator #112 provided inspector with staff training records for the minimizing of restraining.

Review of the staff training records with HR Coordinator #112 noted that staff had not received training for the minimizing of restraining in 2019. HR Coordinator #112 confirmed that staff training records indicated that staff had not completed training for the minimizing of restraining since 2017.

C) On a specific date, resident #005 was observed with a PASD in place. The PASD was not applied appropriately.

Resident #005 stated they were able to apply the PASD on their own. PSW #108 stated that they had assisted resident #005 to apply the PASD and that it was normal for resident #005 to have the PASD applied that way.

Inspector went to Therapy Coordinator (TC) #102 and asked the TC to observe resident #005. TC #102 observed resident #005 and stated their PASD was not applied appropriately. TC #102 reapplied the PASD appropriately.

In an interview, TC #102 stated that resident #005 used a specific type of PASD.

Review of the manufacturer's instructions for the specific type of PASD noted the PASD had not been applied as per the manufacturer's instructions.

In an interview, Assistant Director of Resident Care (ADRC) #100 stated that when staff applied the PASD they should ensure it is applied appropriately.

The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was level 3 as it was widespread. The home had a level 2 compliance history with a different subsection of Ontario

Ontario

Ministry of Long-Term Care

Ministère 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

Regulation 79/10. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 30, 2020

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 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 16th day of June, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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