Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 29, 2014	2014_198117_0013	O-000404-14	Complaint

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr., OTTAWA, ON, K1V-8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 13,14 and 15, 2014

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer, Vice President of Clinical Care, Registered Dietitian, a Nutritional Manager, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Restorative Care Manager, a Nutritional Services Aide, a Recreologist, several residents, a private caregiver and a family member.

During the course of the inspection, the inspector(s) reviewed the health care records of several identified residents, observed lunch time meal service of May 14, 2014, observed the provision of care and services, reviewed the home's Falls Prevention and Management Program.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 49. (2) in that the long-term care home did not ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is

conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #1 was admitted to the home on an identified day in January 2014. At the time of admission, the resident was ambulating with no aids. In February 2014, the resident had falls on two identified days in February, within a 72 hours period. The resident did not sustain any injuries but was sent to hospital to due complaints of headaches. Resident #1 returned to the home and was closely monitored. The attending physician assessed the resident and changed some of his/her cardiac medication.

In March the resident had a total of 6 falls. The resident did not sustain any injuries. For each fall the resident was assessed and closely monitored. Fall preventions interventions were put in place, after the 3rd fall; on a specified day in March, hip protectors were given to the resident and three days later after the 6th fall, a flat call bell was given to facilitate Resident #1's use of the resident-staff communication response system.

In April the resident had a total of 4 falls. On a specified day in April, after the second fall, the resident was sent to hospital for assessment. Hospital assessments did not identify any causal factors related to Resident #1's falls. The next day, Resident #1 fell and sustained an injury with bruising to the side of his/her head. The resident was assessed and closely monitored at the home. The resident was not sent to hospital for reassessment at that time as per Power of Attorney (POA) request. Resident #1 sustained a 4th fall the following day. Although the resident did not sustain any further injuries, he/she was assessed, and closely monitored. On the fourth day after the last fall in April, at POA's request, the resident was sent to hospital for assessment. Hospital assessments did not identify any causal factors related to Resident #1's falls. Two days later, a request was made to have a bed alarm and a wheelchair to help the resident mobilize for long distances. These fall prevention interventions were implemented with the consent of the Resident #1's POA the next day.

In May Resident #1 had a total of 8 falls. Resident #1 did hit his/her head when he/she had a second fall during one night in May. The resident was assessed, noted not to have any injuries and was put on Head Injury Routines. The next day, Resident #1 had another fall and sustained a laceration to his/her head. The resident was sent to hospital for assessment and returned later that same day. Hospital assessments did not identify any causal factors related to Resident #1's falls.

One day after the resident's transfer and assessment in hospital, the home received a call from the hospital requesting to send to the Resident #1 back to the hospital as some test results indicated that the resident had sustained an injury. Resident #1 was sent once again to hospital. Resident #1 returned to the home three days later with a diagnosed injury. Within 1 hour of his/her return, Resident #1 had another fall when he/she went to the bathroom without calling for assistance. The resident was assessed; the attending physician was notified and requested that Resident #1 be sent back to the hospital for re-assessment of the resident's condition. The resident returned to the home two days later. Upon the resident's return, the fall prevention intervention implemented, with the consent of the POA, was the use of a wheelchair with lap belt restraint. That evening, a few minutes after the resident was positioned in bed, Resident #1 was found on the floor at the foot of his/her bed. The resident was assessed and noted not to have any injuries.

A review of the resident's health care record shows that no post-fall assessment, using a clinically appropriate tool specifically designed for falls, was done for the Resident #1 after his many falls. On May 14, 2014, RN S#101 stated to Inspector #117 that although she did assess Resident #1's condition when he/she had falls during the shifts she worked, she did not complete any post-fall assessments related to Resident #1's many falls. RN S#101 stated that she did discuss various fall interventions with Resident #1's family and POA however these were not consistently documented in the resident's chart or plan of care.

On May 13, 2014, the home's Restorative Care Lead stated to Inspector #117 that at this time the home does have a clinically appropriate post-fall assessment tool, however it is not fully implemented within the home. The Restorative Care Lead stated that Resident #1 was not referred to the restorative care services to review some fall prevention interventions until a specific day in April, this after Resident #1 had sustained 12 falls, some with injuries. The Restorative Care Manager stated that the use of hip protectors and a flat call bell, implemented on two identified days in March were nursing interventions. It was on the day of the April referral, that restorative care services implemented the use of a bed alarm and a wheelchair for distance mobility after Resident #1 had sustained 4 more falls in April, with injuries. The Restorative Care Lead stated to Inspector #117, that the home does have a Falls Prevention and Management Program Policy #PART II-R49, dated 2011-07-15, which identifies the use of a post-fall assessment tool (RAI-MDS 2.0) when residents' have a change in health status that puts them at increased risk for falling.

The Falls Prevention and Management Program policy was reviewed. It identifies the following as being indicators for doing post-fall assessments: 2 falls in 72 hours, more than 3 falls in 3 months, more than 5 falls in 6 months, significant change in health status and falls resulting in injuries. A review of Resident #1's health care record shows that no post-fall assessment (RAI-MDS 2.0) or any other post fall assessment tool was completed for Resident #1 when he/she had 20 falls in 3 ½ months and when the resident had multiple episodes of 2 -3 falls within 72 hours in February, March, April and May 2014. This was confirmed by unit RN S#101 and the Restorative Care Lead. [s. 49. (2)]

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O.2007, c.8, s. 6.(10) (b) in that it did not ensure that identified residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the residents' care needs changed.

Resident #2 is identified as being at high nutritional risk due to advanced cognitive impairment. The resident is on a minced texture diet and requires feeding assistance. Progress notes in the resident's health care record document the following:
- On a specific day in January 2014, one of the home's nutritional managers notes that

Resident #2 has a slight weight loss of 0.4 kg in 1 month , weight loss of 0.9kg overall in the past 3 months. The nutritional manager had done dietary observations of the resident on a specified day in January.
- On a specific day in February 2014, the resident's attending physician noted that she was aware of the resident's weight loss.
- On a specific day in February 2014, the recreologist advises the unit RPN, that Resident #2 is barely eating and not opening his/her mouth while feeding. The RPN completes a nutritional concern form. No follow up related to these concerns were done by dietary services until a specified day in April 2014, 6 weeks after the request, by a Nutritional Manager.
- On two identified days in March, the attending physician notes document her monitoring of the resident's weight, that the resident's intake is variable and that the resident had lost 1kg from the previous month.
- Resident #2's weight was not taken in early April.
- On a specified day in April, a Nutrition Manager observed Resident #2 during meal service in regards to the February dietary referral.
- The next day in April, the attending physician made an Order to have Resident #2's weight taken. This was not done until 4 days later in April when the resident was seen by the Nutrition Manager who noted a significant weight loss of 6 kg in 1 month.
- The day after the noted weight loss was identified, the unit RN notified Resident #2's POA of the weight loss and a referral to home's Registered Dietitian (RD) was made. The RD assessed Resident #2 that same day. The next day, after discussion with the POA, Resident #2 was started on a dietary supplement.

On May 13, 2014, the Registered Dietitian stated to Inspector #117, that over the past few months, there have been various issues related to the home's assessment and communication processes between nursing and dietary services. When there is a change in residents weights, +/- 2kg in a month, nursing staff are to re-weight residents. If the weight change is similar, a nutritional referral is to be completed for immediate follow up. The Registered Dietitian states that the only referral she received for Resident #2 was the one received on an identified day in April, which she completed the same day due to the resident's significant weight loss.

On May 13, 2014, RPN S#102 and RN S#101, stated to Inspector #117, that the resident weights are to be taken the first week of each month. Weights are to be reviewed that week. Any change of +/- 2kgs triggers an automatic re-weighing of the resident presenting weight changes. If the change is still present, then a nutritional concern form is completed and sent to the home's nutritional managers and

Registered Dietitian for follow up. Both stated that in the past few months, there have been delays in the taking of resident monthly weights, re-assessment of weight changes and referrals to nutritional services.

On May 15, 2014, Nutritional Manager S#109 stated to Inspector #117 that dietary services did not receive a nutritional concern form in February or March in regards to Resident #2's decreased food intake. She states that on an identified day in April, during her regular quarterly observation of Resident #2's nutritional intake and needs, she was not informed by nursing staff of any concerns related to Resident #2.

The home's nursing staff did not ensure that Resident #2's weight and nutritional needs be reassessed when the resident was noted to have some weight loss and difficulties eating in February and March 2014. [s. 6. (10) (b)]

2. Resident #1 was admitted to the home on a specific day in January 2014. Resident #1 was identified as being at moderate nutritional risk due to his/her low admission weight of 69 kgs. The resident was placed on modified diabetic diet, with additional dietary interventions as the goal was to increase his/her weight. This plan was reviewed and approved by the home's RD and Resident #1's POA on a specified day in February 2014.

Resident #1's weight was monitored monthly in February and March 2014. March weight was 67.0 kgs. On a specified day in April, Resident #1 weighed 61.1 kgs and the resident was re-weighed as being 59.1 kgs four days later . Resident #1 has a weight loss of 7.9kg in a 6 week period. On the day of the re-weigh, Resident #1's dietary needs were reassessed by the RD when the resident's significant weight loss was noted. Changes were made to the resident's dietary plan of care. These were communicated and approved by Resident #1's POA that same day in April. Resident #1's weight was noted to have been taken 10 days after the interventions were put in place. This was noted to be 59.4kgs.

On May 14, 2014, Resident #1 was observed by Inspector #117 to ask for a specific beverage several times in the morning after breakfast and during the lunch time meal. Resident #1's POA, who was present, informed the resident that the requested beverage was not available. Resident #1 threw some food to the floor and refused to eat his/her lunch time meal even when the POA and nursing staff tried to encourage him/her to eat. Resident's POA stated to Inspector #117 on May 14, 2014, that

Resident #1 did consume on a daily basis the requested beverage prior to his/her admission but feels that this is not part of the issue as to why the resident is not eating. The issue is that the resident is not on a more cognitively alert unit.

PSW S#108 stated to Inspector #117 on May 14, 2014, that this is not the first time that Resident #1 is expressing a need to have the specific beverage and then refuses to eat part of his/her meal. Registered staff member S#101 stated to Inspector #117 on May 14, 2014, that she had not been informed of any issues related to the resident requesting a specific beverage and refusing to eat some or part of his/her meals. The RN S#101 stated that she was aware of an incident in February 2014 when the resident was found in his/her room smelling like the specified beverage. Resident #1 had informed RN staff member that he/she had received the beverage from a family member. The RN stated that she had discussed the issue of not bringing the beverage to the home with the resident’s POA.

Resident #1’s dietary needs and plan of care interventions were reassessed and revised when there was a significant weight loss of 7.9kgs in a 6 week period. However, there is no identification of behaviours linked to Resident #1’s food intake, especially as it relates to a specific beverage. Resident #1’s plan of care was not reviewed and reassessed in regards to potential responsive behaviours and the resident's decreased food intake. [s. 6. (10) (b)]

3. Resident #1 suffers from diabetes and vascular disease. On two specific days in February and again in April Resident #1 was diagnosed as having a leg infection and was treated with an antibiotic medication. On a specified day in February 2014, Resident #1 developed a blister that created a skin tear on a toe. The wound was noted by nursing staff during provision of care. Progress notes document that the wound was cleansed and a dressing applied. New wounds on the resident’s toes were also noted on a specific day, later in April 2014. The wounds were also cleansed and a medical solution treatment was applied. Progress notes also document that the resident’s family expressed concern related to the provision of nail and foot care.

A review of Resident #1’s health care record was conducted by Inspector #117. The following was noted.
- On two identified days in February and April 2014, Resident #1 was diagnosed as having a leg infection. The start of the antibiotic treatment for Resident #1’s infection was noted in the resident’s chart. However there is no documentation of any

monitoring of the effectiveness of the antibiotic treatments or of the resident's leg status during the antibiotic treatments in both February and in April 2014.
- On a specified day in February 2014, the attending physician requested that a week long sleep audit be completed for Resident #1. No information was found in the resident's chart related to a sleep audit.
- On a specified day in February 2014, documentation does indicate the presence of a blister skin tear on one of Resident #1's toes. Notes do not identify which toe the wound is on. Nor is there any other information related to the monitoring, reassessment and treatment of the wound noted in the resident's chart.
- On a specified day in April 2014, new wounds were noted on several of Resident #1's toes. A medical solution treatment was noted to have been done for 9 days in April 2014. No further information was found in the chart related to the status of the resident's wounds.
- On a specified day in April, Resident #1's family expressed concerns to registered staff in regards to the lack of foot nail care. Resident #1 has thick discoloured toe nails. A review of the resident's daily care flow sheets for February, March, April and May 2014 was done. No information related to the provision of nail care was noted in the resident's chart. On a specific day in April, 6 days after the expressed concern, a referral to the advanced foot care nurse was completed. No further information related to any further provision of nail care was noted in the resident's chart.

On May 13, 2014, unit RPN S#103 examined Resident #1's feet in the presence of Inspector #117. Several dry reddish spots of were noted on both lower legs. The resident's toe nails on both feet were noted to be thick, long and discoloured. On the right foot a dry raised scab was noted. On another toe of the left foot were two scabbed round raised areas and 2 small dry reddish areas on another toe. RPN S#103 stated to Inspector #117 that she is not a regular registered staff member on the unit. She stated that she was not aware that Resident #1 had any skin integrity issues or dry scabbed wounds on his/her feet. A review of the resident's plan of care with RPN S#103 was done. No information on the plan of care was found related to Resident #1's wounds, nail care needs or past leg infections.

Unit RN S#101 stated to Inspector #117 on May 14, 2014, that when a resident has skin integrity issues and wounds, nursing staff are to assess, monitor and put in place interventions to address these issues and put these in the resident's plan of care. S#101 could not explain why this was not done for Resident #1 as it relates to his/her two episodes of leg infections and toe wounds. Also she could not explain why no information was found in the resident's chart as it relates to a requested sleep

assessment in February 2014 nor could she give any information as it relates to Resident #1's provision of regular nail care by PSW staff. RN S#101 stated that the high number of new admissions within the past 4 month period as well as changing staff on the unit has impacted nursing processes including the re-assessments of resident care needs and revision of resident care plan interventions. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10 s. 107 (3) (4) in that the home did not inform the Director no later than three business days after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Resident #1 is identified as being at high risk for falls. In May Resident #1 had a total of 7 falls. Resident #1 hit his/her head when he/she fell during one identified night in May. The resident was assessed, was noted not to have any injuries and was put on Head Injury Routines. The next day, Resident #1 had another fall and sustained a laceration to his/her head. The resident was sent to hospital for assessment and returned later that same day. Hospital assessments did not identify any causal factors related to Resident #1's falls.

One day after the resident's transfer and assessment in hospital, the home received a call from the hospital requesting to send the resident back to the hospital as some test results indicated that the resident had sustained an injury. Resident #1 was sent once again to hospital.Resident #1 returned to the home two days later with a diagnosis. Within 1 hour of his/her return, the resident had another fall. The resident was assessed; the attending physician was notified and requested that Resident #1 be sent back to the hospital for a re-assessment of the resident's condition. The resident remained in hospital for two more days when he/she was returned to the home.

The home did not notify the Director of Resident #1's admission to hospital on a specified day in May for an injury or of his re-admission, when the resident had another fall. The home completed and submitted a Critical Incident Report to the Director on a specified day in May. This is 8 days after Resident #1's first admission and 5 days after his second admission to hospital.

On May 14, 2014, the home's Vice President of Clinical Care stated to Inspector #117 that the Critical Incident Report was not submitted to the Director until a specified day in May 2014. She stated that the registered nursing staff reported having IT issues and did not submit the Critical Incident Report. The Vice President stated that the home's registered nursing staff do have the Director's after-hours contact number however the staff did not contact and notify the Director of Resident #1 admission and readmission to the hospital when he/she had a significant change in condition. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Director is informed, no later then three business days, after the occurrence of an incident that causes an injury to a resident that results in a significant change the resident's health condition and for which the resident is taken to hospital, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O.2007, c.8, s. 31 (3) (b) in that residents who are being restrained by a physical device under subsection 1, the licensee did not ensure that the residents are monitored while restrained, in accordance with the requirements provided for under the regulations.

O.Reg. 79/10 s. 110 (2) states that every licensee shall ensure that the following requirements are met where a resident in being restrained by a physical device under section 31 of the Act:
3.- That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. - That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Resident #3 was admitted to the home on specified day in May 2014. The physician ordered the use of a lap belt restraint when the resident is up in his/her wheelchair. The resident's Power of Attorney (POA) consented to the use of a lap belt as a

physical restraint. The resident's 24-hours admission plan of care identifies the use of the restraint. Unit nursing staff were informed of the use of the physical restraint the time of the resident's admission. Restraint monitoring forms were initiated. Documentation indicates that on the day of admission and the next day, the lap belt was applied and monitored at 15:00 hrs only. No other information is noted related to the use, application, monitoring, repositioning, removal of the physical device during the evening of the resident's admission, during the next two days and evening shifts. It is noted that staff have been monitoring and documenting the use, application, repositioning and removal of the lap belt on day and evening shift on day third and fourth days post Resident #3's admission in May 2014.

Staff members S#110 and S#111 stated to Inspector #117 on May 14, 2014, that the home's expectation is that staff apply, monitor, reposition and release residents who have physical devices as restraints. PSW actions are to be documented in the Restraint Monitoring Sheet. If this is not done, then it is assumed not to have been done. The staff members stated that they were not working this past weekend and therefore could not comment on care provided to the resident on the 2nd and 3rd day of his/her admission to the home in May 2014.

Resident #2 has advanced dementia and has a wheelchair lap belt restraint. Unit nursing staff PSW S#104 stated to Inspector #117 that the lap belt restraint is applied when the resident is up in his/her wheelchair and that staff are to document it's use, application, monitoring, removal of the restraint and the repositioning of the resident. A review of Resident #2's health care record shows that the Restraint Monitoring Record for the use, application, repositioning, monitoring and removal of the lap belt is not consistently documented by nursing staff. March records shows that on day shift 17/31 days has no documentation, 10/31 evenings has no documentation. A review of April records shows that 20/ 30 days and 15/30 evenings there is no documentation. May records continue to show ongoing gaps in this process.

Staff members PSW S#104 and S#105 stated to Inspector #117 on May 13, 2014, that they have been applying, repositioning, monitoring and releasing the lap belt restraint for Resident #2 since they have been working on the unit. They also report that they do document the care given to Resident #2 in the Restraint Monitoring Record sheet. However they state that in past few months several non-regular staffs have been working on the resident care unit. They are unable to comment on other staffs provision and documentation of restraint care for Resident #2. They report that

the home's expectation is that PSW document the care provided to the residents, this includes the application, repositioning, monitoring and removal of restraints.

Registered Staff member RN S#101, stated to Inspector #117 on May 14, 2014 that she is aware that PSW staff were applying and removing lap belt restraint for Resident #2 but could not determine if the resident was repositioned and monitored when the lap belt restraint was in place as per resident's plan of care.

Resident #1 is identified as being at high risk for falls. On a specified day in May 2014, the attending physician ordered a 10-lbs pressure release seat belt to be used as a restraint when the resident is up in a wheelchair. Resident #1's POA did give consent to the use of the lap belt restraint. The resident's plan of care was updated to reflect the use of a lap belt restraint. Progress notes document that this intervention was communicated to unit nursing staff on that same day in May 2014.

On May 13, 2013 unit RPN S#103 and PSW S#104 and S#105 stated that they were aware of the resident's risk for falls and that he/she had a lap belt restraint in place when he/she is up in his/her wheelchair. A review of Resident #1's Restraint Monitoring Record, initiated on a specified day in May 2014, shows that the use, application, monitoring of resident's response to the restraint, repositioning and removal of the restraint was done on the evening, the restraint was ordered. No other documentation related to the use of the 10-lbs lap belt restraint is found on the Restraint Monitoring Record for the next four days. Resident #1's Restraint Monitoring Record was not found in the resident's chart but on the unit nursing station conference table. Staff member RPN #S103 stated to Inspector #117 that she did not know why the record was not in the resident's chart or why it was not being used to monitor the use, application, repositioning, removal of the restraint or of the resident's response to the use of the lap belt restraint. She did confirm that the lap belt restraint was being applied but could not confirm if Resident #1 was being monitored and repositioned as per plan of care.

Note that a Compliance Order CO #002 for LTCHA 2007, S.O.2007, c.8, s. 31 was issued on May 9, 2014, Inspection # 2014-198117-0011. Full compliance for this Compliance Order is due on June 30, 2014. Therefore, the above evidence is additional information for Compliance Order CO #002. [s. 31. (3) (b)]

Issued on this 9th day of June, 2014

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

Lyne Duchesne RN #117.

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8	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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117)
Inspection No. / No de l'inspection :	2014_198117_0013
Log No. / Registre no:	O-000404-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 29, 2014
Licensee / Titulaire de permis :	ST. PATRICK'S HOME OF OTTAWA INC. 2865 Riverside Dr., OTTAWA, ON, K1V-8N5
LTC Home / Foyer de SLD :	ST PATRICK'S HOME 2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LINDA CHAPLIN

To ST. PATRICK'S HOME OF OTTAWA INC., 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance as it relates to the following:
- That a post fall assessment, using a clinically appropriate assessment instrument that is specifically designed for falls, be completed for residents who have fallen and who have a significant change of condition or who have frequent falls.
- Registered nursing staff and other members of the multidisciplinary team who do post fall assessments receive training on the use of the home's clinically appropriate post fall assessment instrument

This plan must be submitted in writing to Lyne Duchesne, LTCH Inspector at 347 Preston St, 4th floor, Ottawa ON, K1S 3J4 or by fax (613) 569-9670 on or before June 6, 2014.

Grounds / Motifs :

1. 1. The licensee failed to comply with O.Reg 79/10 s. 49. (2) in that the long-term care home did not ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #1 was admitted to the home on an identified day in January 2014. At the time of admission, the resident was ambulating with no aids. In February 2014, the resident had falls on two identified days in February, within a 72 hours period. The resident did not sustain any injuries but was sent to hospital to due

complaints of headaches. Resident #1 returned to the home and was closely monitored. The attending physician assessed the resident and changed some of his/her cardiac medication.

In March the resident had a total of 6 falls. The resident did not sustain any injuries. For each fall the resident was assessed and closely monitored. Fall preventions interventions were put in place, after the 3rd fall; on a specified day in March, hip protectors were given to the resident and three days later after the 6th fall, a flat call bell was given to facilitate Resident #1's use of the resident-staff communication response system.

In April the resident had a total of 4 falls. On a specified day in April, after the second fall, the resident was sent to hospital for assessment. Hospital assessments did not identify any causal factors related to Resident #1's falls. The next day, Resident #1 fell and sustained an injury with bruising to the side of his/her head. The resident was assessed and closely monitored at the home. The resident was not sent to hospital for reassessment at that time as per Power of Attorney (POA) request. Resident #1 sustained a 4th fall the following day. Although the resident did not sustain any further injuries, he/she was assessed, and closely monitored. On the fourth day after the last fall in April, at POA's request, the resident was sent to hospital for assessment. Hospital assessments did not identify any causal factors related to Resident #1's falls. Two days later, a request was made to have a bed alarm and a wheelchair to help the resident mobilize for long distances. These fall prevention interventions were implemented with the consent of the Resident #1's POA the next day.

In May Resident #1 had a total of 8 falls. Resident #1 did hit his/her head when he/she had a second fall during one night in May. The resident was assessed, noted not to have any injuries and was put on Head Injury Routines. The next day, Resident #1 had another fall and sustained a laceration to his/her head. The resident was sent to hospital for assessment and returned later that same day. Hospital assessments did not identify any causal factors related to Resident #1's falls.

One day after the resident's transfer and assessment in hospital, the home received a call from the hospital requesting to send to the Resident #1 back to the hospital as some test results indicated that the resident had sustained an injury. Resident #1 was sent once again to hospital. Resident #1 returned to the home three days later with a diagnosed injury. Within 1 hour of his/her return,

Resident #1 had another fall when he/she went to the bathroom without calling for assistance. The resident was assessed; the attending physician was notified and requested that Resident #1 be sent back to the hospital for re-assessment of the resident's condition. The resident returned to the home two days later. Upon the resident's return, the fall prevention intervention implemented, with the consent of the POA, was the use of a wheelchair with lap belt restraint. That evening, a few minutes after the resident was positioned in bed, Resident #1 was found on the floor at the foot of his/her bed. The resident was assessed and noted not to have any injuries.

A review of the resident's health care record shows that no post-fall assessment, using a clinically appropriate tool specifically designed for falls, was done for the Resident #1 after his many falls. On May 14, 2014, RN S#101 stated to Inspector #117 that although she did assess Resident #1's condition when he/she had falls during the shifts she worked, she did not complete any post-fall assessments related to Resident #1's many falls. RN S#101 stated that she did discuss various fall interventions with Resident #1's family and POA however these were not consistently documented in the resident's chart or plan of care.

On May 13, 2014, the home's Restorative Care Lead stated to Inspector #117 that at this time the home does have a clinically appropriate post-fall assessment tool, however it is not fully implemented within the home. The Restorative Care Lead stated that Resident #1 was not referred to the restorative care services to review some fall prevention interventions until a specific day in April, this after Resident #1 had sustained 12 falls, some with injuries. The Restorative Care Manager stated that the use of hip protectors and a flat call bell, implemented on two identified days in March were nursing interventions. It was on the day of the April referral, that restorative care services implemented the use of a bed alarm and a wheelchair for distance mobility after Resident #1 had sustained 4 more falls in April, with injuries. The Restorative Care Lead stated to Inspector #117, that the home does have a Falls Prevention and Management Program Policy #PART II-R49, dated 2011-07-15, which identifies the use of a post-fall assessment tool (RAI-MDS 2.0) when residents' have a change in health status that puts them at increased risk for falling.

The Falls Prevention and Management Program policy was reviewed. It identifies the following as being indicators for doing post-fall assessments: 2 falls in 72 hours, more than 3 falls in 3 months, more than 5 falls in 6 months, significant change in health status and falls resulting in injuries. A review of

Resident #1's health care record shows that no post-fall assessment (RAI-MDS 2.0) or any other post fall assessment tool was completed for Resident #1 when he/she had 20 falls in 3 ½ months and when the resident had multiple episodes of 2 -3 falls within 72 hours in February, March, April and May 2014. This was confirmed by unit RN S#101 and the Restorative Care Lead. [s. 49. (2)] (117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance as it relates to the following:
- Residents who have a significant change in their chewing/swallowing abilities are referred for a nutritional assessment in a timely manner
- Residents who have a significant weight loss are reassessed and their plans of care revised by nutritional services and nursing services to identify both dietary needs and responsive behaviours that may impact residents nutritional intake
- Residents have their plan of care reviewed and their care needs reassessed when the residents present with changes in their nail care, when there is potential/actual skin breakdown issues, and infections.
- That specific resident assessments, requested by attending physicians, be completed and documented as per medical request.

This plan must be submitted in writing to Lyne Duchesne, LTCH Inspector at 347 Preston St, 4th floor, Ottawa ON, K1S 3J4 or by fax (613) 569-9670 on or before June 6, 2014.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA 2007, S.O.2007, c.8, s. 6.(10) (b) in that it did not ensure that identified residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the residents' care needs changed.

Resident #2 is identified as being at high nutritional risk due to advanced cognitive impairment. The resident is on a minced texture diet and requires feeding assistance.
Progress notes in the resident's health care record document the following:
- On a specific day in January 2014, one of the home's nutritional managers notes that Resident #2 has a slight weight loss of 0.4 kg in 1 month , weight loss of 0.9kg overall in the past 3 months. The nutritional manager had done dietary observations of the resident on a specified day in January.
- On a specific day in February 2014, the resident's attending physician noted that she was aware of the resident's weight loss.
- On a specific day in February 2014, the recreologist advises the unit RPN, that Resident #2 is barely eating and not opening his/her mouth while feeding. The RPN completes a nutritional concern form. No follow up related to these concerns were done by dietary services until a specified day in April 2014, 6 weeks after the request, by a Nutritional Manager.
- On two identified days in March, the attending physician notes document her monitoring of the resident's weight, that the resident's intake is variable and that the resident had lost 1kg from the previous month.
- Resident #2's weight was not taken in early April.
- On a specified day in April, a Nutrition Manager observed Resident #2 during meal service in regards to the February dietary referral.
- The next day in April, the attending physician made an Order to have Resident #2's weight taken. This was not done until 4 days later in April when the resident was seen by the Nutrition Manager who noted a significant weight loss of 6 kg in 1 month.
- The day after the noted weight loss was identified, the unit RN notified Resident #2's POA of the weight loss and a referral to home's Registered Dietitian (RD) was made. The RD assessed Resident #2 that same day. The next day, after discussion with the POA, Resident #2 was started on a dietary supplement.

On May 13, 2014, the Registered Dietitian stated to Inspector #117, that over the past few months, there have been various issues related to the home's assessment and communication processes between nursing and dietary services. When there is a change in residents weights, +/- 2kg in a month, nursing staff are to re-weight residents. If the weight change is similar, a nutritional referral is to be completed for immediate follow up. The Registered Dietitian states that the only referral she received for Resident #2 was the one

received on an identified day in April, which she completed the same day due to the resident's significant weight loss.

On May 13, 2014, RPN S#102 and RN S#101, stated to Inspector #117, that the resident weights are to be taken the first week of each month. Weights are to be reviewed that week. Any change of +/- 2kgs triggers an automatic re-weighing of the resident presenting weight changes. If the change is still present, then a nutritional concern form is completed and sent to the home's nutritional managers and Registered Dietitian for follow up. Both stated that in the past few months, there have been delays in the taking of resident monthly weights, re-assessment of weight changes and referrals to nutritional services.

On May 15, 2014, Nutritional Manager S#109 stated to Inspector #117 that dietary services did not receive a nutritional concern form in February or March in regards to Resident #2's decreased food intake. She states that on an identified day in April, during her regular quarterly observation of Resident #2's nutritional intake and needs, she was not informed by nursing staff of any concerns related to Resident #2.

The home's nursing staff did not ensure that Resident #2's weight and nutritional needs be reassessed when the resident was noted to have some weight loss and difficulties eating in February and March 2014. [s. 6. (10) (b)]

2. Resident #1 was admitted to the home on a specific day in January 2014. Resident #1 was identified as being at moderate nutritional risk due to his/her low admission weight of 69 kgs. The resident was placed on modified diabetic diet, with additional dietary interventions as the goal was to increase his/her weight. This plan was reviewed and approved by the home's RD and Resident #1's POA on a specified day in February 2014.

Resident #1's weight was monitored monthly in February and March 2014. March weight was 67.0 kgs. On a specified day in April, Resident #1 weighed 61.1 kgs and the resident was re-weighed as being 59.1 kgs four days later . Resident #1 has a weight loss of 7.9kg in a 6 week period. On the day of the re-weigh, Resident #1's dietary needs were reassessed by the RD when the resident's significant weight loss was noted. Changes were made to the resident's dietary plan of care. These were communicated and approved by

Resident #1's POA that same day in April. Resident #1's weight was noted to have been taken 10 days after the interventions were put in place. This was noted to be 59.4kgs.

On May 14, 2014, Resident #1 was observed by Inspector #117 to ask for a specific beverage several times in the morning after breakfast and during the lunch time meal. Resident #1's POA, who was present, informed the resident that the requested beverage was not available. Resident #1 threw some food to the floor and refused to eat his/her lunch time meal even when the POA and nursing staff tried to encourage him/her to eat. Resident's POA stated to Inspector #117 on May 14, 2014, that Resident #1 did consume on a daily basis the requested beverage prior to his/her admission but feels that this is not part of the issue as to why the resident is not eating. The issue is that the resident is not on a more cognitively alert unit.

PSW S#108 stated to Inspector #117 on May 14, 2014, that this is not the first time that Resident #1 is expressing a need to have the specific beverage and then refuses to eat part of his/her meal. Registered staff member S#101 stated to Inspector #117 on May 14, 2014, that she had not been informed of any issues related to the resident requesting a specific beverage and refusing to eat some or part of his/her meals. The RN S#101 stated that she was aware of an incident in February 2014 when the resident was found in his/her room smelling like the specified beverage. Resident #1 had informed RN staff member that he/she had received the beverage from a family member. The RN stated that she had discussed the issue of not bringing the beverage to the home with the resident's POA.

Resident #1's dietary needs and plan of care interventions were reassessed and revised when there was a significant weight loss of 7.9kgs in a 6 week period. However, there is no identification of behaviours linked to Resident #1's food intake, especially as it relates to a specific beverage. Resident #1's plan of care was not reviewed and reassessed in regards to potential responsive behaviours and the resident's decreased food intake. [s. 6. (10) (b)]

3. Resident #1 suffers from diabetes and vascular disease. On two specific days in February and again in April Resident #1 was diagnosed as having a leg infection and was treated with an antibiotic medication. On a specified day in

February 2014, Resident #1 developed a blister that created a skin tear on a toe. The wound was noted by nursing staff during provision of care. Progress notes document that the wound was cleansed and a dressing applied. New wounds on the resident's toes were also noted on a specific day, later in April 2014. The wounds were also cleansed and a medical solution treatment was applied. Progress notes also document that the resident's family expressed concern related to the provision of nail and foot care.

A review of Resident #1's health care record was conducted by Inspector #117. The following was noted.
- On two identified days in February and April 2014, Resident #1 was diagnosed as having a leg infection. The start of the antibiotic treatment for Resident #1's infection was noted in the resident's chart. However there is no documentation of any monitoring of the effectiveness of the antibiotic treatments or of the resident's leg status during the antibiotic treatments in both February and in April 2014.
- On a specified day in February 2014, the attending physician requested that a week long sleep audit be completed for Resident #1. No information was found in the resident's chart related to a sleep audit.
- On a specified day in February 2014, documentation does indicate the presence of a blister skin tear on one of Resident #1's toes. Notes do not identify which toe the wound is on. Nor is there any other information related to the monitoring, reassessment and treatment of the wound noted in the resident's chart.
- On a specified day in April 2014, new wounds were noted on several of Resident #1's toes. A medical solution treatment was noted to have been done for 9 days in April 2014. No further information was found in the chart related to the status of the resident's wounds.
- On a specified day in April, Resident #1's family expressed concerns to registered staff in regards to the lack of foot nail care. Resident #1 has thick discoloured toe nails. A review of the resident's daily care flow sheets for February, March, April and May 2014 was done. No information related to the provision of nail care was noted in the resident's chart. On a specific day in April, 6 days after the expressed concern, a referral to the advanced foot care nurse was completed. No further information related to any further provision of nail care was noted in the resident's chart.

On May 13, 2014, unit RPN S#103 examined Resident #1's feet in the presence of Inspector #117. Several dry reddish spots of were noted on both lower legs.

The resident's toe nails on both feet were noted to be thick, long and discoloured. On the right foot a dry raised scab was noted. On another toe of the left foot were two scabbed round raised areas and 2 small dry reddish areas on another toe. RPN S#103 stated to Inspector #117 that she is not a regular registered staff member on the unit. She stated that she was not aware that Resident #1 had any skin integrity issues or dry scabbed wounds on his/her feet. A review of the resident's plan of care with RPN S#103 was done. No information on the plan of care was found related to Resident #1's wounds, nail care needs or past leg infections.

Unit RN S#101 stated to Inspector #117 on May 14, 2014, that when a resident has skin integrity issues and wounds, nursing staff are to assess, monitor and put in place interventions to address these issues and put these in the resident's plan of care. S#101 could not explain why this was not done for Resident #1 as it relates to his/her two episodes of leg infections and toe wounds. Also she could not explain why no information was found in the resident's chart as it relates to a requested sleep assessment in February 2014 nor could she give any information as it relates to Resident #1's provision of regular nail care by PSW staff. RN S#101 stated that the high number of new admissions within the past 4 month period as well as changing staff on the unit has impacted nursing processes including the re-assessments of resident care needs and revision of resident care plan interventions. [s. 6. (10) (b)]
(117)

2.

(117)

3.

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Issued on this 29th day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Lyne Duchesne RN #117

Name of Inspector / Nom de l'inspecteur : LYNE DUCHESNE

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