Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 12, 2014	2014_322156_0004	H-000869-13/H-000870-13	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

TELFER PLACE
245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8

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

CAROL POLCZ (156), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 15-29, 2014

This inspection was a follow up to H-000229-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI/MDS Coordinator/Assistant DOC, physiotherapist, Registered Dietitian, Food Services Manager, registered staff, dietary staff, personal support workers, families and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services including meal and snack services and reviewed relevant documents including but not limited to resident clinical records, menus, policies and procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Nutrition and Hydration
Snack Observation

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other.
Staff involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were consistent with each other.

a) The plan of care for resident #102 indicated that the resident was at high nutritional risk and at risk for inadequate fluid intake. The calculated target fluid intake requirement was 1700 ml/day and target beverage intake (based on 75% of the total fluid) was calculated to be 1275 ml/day. Nursing staff identified in the progress notes that the resident had not met their calculated daily fluid requirement for three consecutive days on ten separate occasions from to March 1-April 22, 2014. The Registered Dietitian confirmed during interview on April 23, 2014, that a referral to dietary was not sent regarding the residents' hydration status. A review of the fluid intake flow-sheet, indicated that the resident had not met their daily target beverage intake of 1275 ml/day on 49/53 days or 92% of the time from March 1-April 22, 2014. The staff failed to collaborate with each other in the assessment of hydration of this resident and the assessment was not integrated and consistent with each other.

b) The plan of care for resident #103 indicated that the resident was at moderate nutritional risk and at risk for hydration due to poor fluid intake. The calculated fluid intake was a minimum of 1500 ml/day and target daily beverage intake was 1125 based on 75% of total fluid intake. Nursing staff identified in the progress notes that the resident had not met their calculated daily fluid requirement for three consecutive days on four separate occasions from March 1- April 23, 2014. The Registered Dietitian confirmed during interview on April 23, 2014, that a referral to dietary was not sent regarding the residents' hydration status. A review of the fluid intake flow-sheets indicated that the resident had not met their daily target beverage intake of 1125 ml/day on 32/54 or 55% of the time from March 1-April 23, 2014. The staff failed to collaborate with each other in the assessment of hydration of this resident and the assessment was not integrated and consistent with each other. [s. 6. (4)]

2. Nursing staff confirmed that they did not collaborate with physiotherapy staff in the assessment of resident #102 related to the risk of falling and falls.
Resident #102 was identified at high risk for falling when nursing staff completed a falls risk assessment in May, 2013. Nursing staff confirmed that they did not seek the collaboration of physiotherapy staff in the completion of this risk assessment. Risk factors identified by nursing on this assessment, including confusion, resident non-compliance as well as anti-anxiety and laxative medication were not considered in the assessments completed by physiotherapy staff.
Staff and clinical records confirmed that this resident fell in December, 2013, and on two separate dates in April, 2014. The resident was assessed after these falls; however the circumstances that lead to the above noted falls were not incorporated into the Resident Assessment Protocols (RAPs) completed in August, and November 2013 and February, 2014 and the care for the resident was not changed to reflect the circumstances causing the resident to fall. Nursing staff confirmed that they did not seek the collaboration of physiotherapy staff in the collection of data or the completion of the Resident Assessment Protocol (RAP) related to falling when the above noted assessments were completed.
Physiotherapy staff completed three quarterly assessments for this resident in August, and November 2013 and February, 2014 and nursing staff confirmed that they did not collaborate with physiotherapy staff in completing these assessments. Other factors identified by physiotherapy staff on these assessments were not incorporated into assessments completed by nursing over the same time period and the care directions identified for staff in managing the risk of falling did not include these factors identified in physiotherapy assessments. Nursing staff confirmed that each discipline completes their own assessments of the residents and they did not discuss the results of their

assessments. [s. 6. (4) (a)]

3. Resident #001 was not provided with care as specified in the plan of care. The resident's plan of care directed that the resident's call bell was to be secured to the side rail as an intervention to manage a high risk for falling. On April 15, 2014 at 1420hrs the resident was interviewed and it was noted the call bell was wrapped around a mirror hanging on the wall at the head of the bed. Although the resident attempted to reach the call bell, it was demonstrated that the position of the call bell prevented the resident from reaching the call bell to call for assistance.
Resident #002 was not provided with care as specified in the plan of care. The resident's plan of care directed that the resident was to be assisted to the toileted after meals. On April 16, 2014 the resident was moved into the lounge after lunch without being toileted. The Personal Support Worker (PSW) providing care to the resident was approached at 1400hrs and indicated that the resident was not toileted after lunch because other residents required care. This PSW also confirmed that the resident can be resistive to care and should be assisted to the toilet immediately when exiting the dining room.
Resident #003 was not provided with care as specified in the plan of care. The resident's plan of care directed that the resident was to have a specified treatment applied to a specified limb continuously and the limb was to be elevated whenever possible in order to manage a risk of altered skin integrity related to edema. On April 15, 2014 at 1620hrs the resident was noted to be sitting in a wheelchair and did not have the treatment applied and the limb was not elevated. The registered staff confirmed that the treatment was not applied and the resident's wheelchair was not adapted to allow for the resident's limb to be elevated. The registered staff confirmed that there was not a strategy in place to ensure that the resident's limb could be elevated while sitting in the wheelchair and that this resident would spend a significant amount of each day sitting in the wheelchair. [s. 6. (7)]

4. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in their plans of care.
a) The plan of care dietary serving notes indicated that resident #104 disliked milk and water to drink at meals, however, was provided these during the observed lunch meal on April 16, 2014.
b) The plan of care dietary serving notes indicated that resident #105 disliked water to drink at meals, however, was provided water during the observed lunch meal on April 22, 2015. Notes also indicate that the resident was to be provided with crustless bread for sandwiches and toast, however, the resident received regular bread with

crust on the sandwich on this date.
c) The plan of care dietary serving notes for resident #106 indicated that the resident was to be provided with small portions, however, was observed receiving regular portions on April 16 and 22, 2014.
d) The plan of care dietary serving notes for resident #001 indicated that the resident disliked milk to drink at meals, however, was provided milk to drink during the observed lunch meal on April 16, 2014.
e) The plan of care nourishment serving notes for resident #107 indicated that the resident was to be provided with assorted gelatin during the am nourishment. The resident was not provided this during the observed nourishment pass on April 16, 2014.
f) The plan of care nourishment serving notes for resident #108 indicated that the resident was to be provided with 100g vanilla yogurt during the am nourishment. The resident was not provided this during the observed nourishment pass on April 16, 2014.
g) The plan of care nourishment serving notes for resident #109 indicated that the resident was to be provided with vanilla pudding cup during the am nourishment. This was not available and therefore the resident was not provided this during the observed nourishment pass on April 16, 2014
h) The plan of care for resident #111 indicated that the resident attends the late breakfast, however, the it also indicated that the resident eats better when hot entrees are provided at meals as opposed to cold entrees. The resident was observed on April 22, 2014 in the main dining room at 10:30 hours being provided a muffin and banana for breakfast.
i) The plan of care indicated that resident #110 preferred to wake around 08:00 hours and have a hot breakfast. On April 22, 2014, it was noted that the resident received the continental breakfast and was observed at 10:30 hours in the main dining room being provided with a yogurt and puree Danish. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

Resident #111 was observed being fed during the lunch meal on April 16, 2014 and was not able to feed herself. The care plan for this resident, however, indicated that the resident only required assistance and encouragement in eating. The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

6. The licensee did not ensure that resident #102's plan of care was reviewed and revised when the care set out in the plan was not effective, in relation to the following: [6(10)(c)]
Resident #102 was assessed at being a high risk for falling when staff completed a falls risk assessment in May, 2013. Clinical records indicated that the resident fell three times in a four month period. Although nursing and physiotherapy staff completed separate assessments related to falling, both in the post fall period and during scheduled RIA-MDS assessments, care directions for staff identified in the care plan were not reviewed or revised when the resident continued to fall. Staff confirmed that the last change in directions for care was made in May, 2013. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 care is provided as specified in resident plans of care, and plans of care are reviewed and revised when the care set out in the plan was not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents and an organized program of hydration for the home to meet the hydration needs of the residents.
The breakfast meal service extended from 08:00 hours until 11:00 hours during the

inspection and staff confirmed that this was the regular practice of the home. The home had a hot breakfast meal service beginning at 08:00 hours which was available until 09:30 hours. The FSM confirmed that the morning snack menu was also the continental breakfast menu which consisted of yogurt or cheese with a muffin, scone or Danish There were a number of residents noted to be on the late breakfast (continental) plan, however, because several of these residents required assistance, these residents were not given an opportunity for a hot breakfast. These residents would then be offered the later breakfast which would run late and then the prescribed am snack was not given or it was refused by the resident as it was too close to lunch time.

On April 23, 2014 the morning snack cart was observed in the main dining room at 11:15. The nourishment pass was complete and the cart was ready to be emptied. It was noted that there were two labelled beverages which were not distributed and remained on the cart: a labelled 250 ml whole milk for resident #102 and 250 ml apple juice for resident #103.

a) Interview with front line staff indicated that resident #102 was not in the dining room for breakfast and was still in bed at 11:00 hours. As a result, the resident was not offered the labelled milk for am snack. Staff indicated that the resident was provided with a bath and then taken to lunch shortly thereafter. The resident was not provided with the labelled milk for am snack and also was not brought to the dining room for breakfast and therefore missed the ordered fibre orange juice as well. The resident was required physical assistance to manoeuvre into dining room. The resident was noted to be at high nutritional risk, had a low BMI and was at risk for dehydration. The home did not have an organized program of hydration to ensure the resident received said beverages in the event of missing breakfast or am snack. The resident was noted to not have met their calculated daily beverage target on 49/53 days or 92% of the time from March 1-April 22, 2014.

b) Interview with staff confirmed that resident #103 refused the labelled juice at am snack as the resident was not in the dining room until after 09:15 hours, and took a long time to eat the breakfast. By the time the resident finished eating breakfast and consuming two beverages during that time, the resident refused the snack beverage. The home did not have an organized program of hydration to ensure the resident was offered the juice at a later time. The resident was noted to be at moderate nutritional risk at risk for dehydration and was noted to have not met their calculated daily beverage target on 32/54 or 55% of the time from March 1-April 23, 2014.

Interview with two staff during the nourishment pass on April 16, 2014 confirmed that since the pass did not start until late, it often was too close to lunch and therefore, residents did not want to eat or drink at snack time. The FSM and RD confirmed on

April 23, 2014 that there was no system in place to ensure that residents received their prescribed fluids at a later time if it was missed during the breakfast or snack pass and therefore, ensure that the hydration needs of the residents were met. [s. 11. (1)]

Additional Required Actions:

CO # - 003 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a Registered Dietitian who is a member of the staff of the home completed a nutritional assessment for all residents when there is a significant change in a resident's health condition and assesses the nutrition status including risks related to nutrition care and hydration status.
a) A review of the plan of care for resident #103 indicated that the resident was administered bowel medication 29 times and had their bowels disempacted during a two month period in 2014, however, constipation was not included on the resident's care plan. As confirmed by the RAI coordinator on April 24, 2014, this should have been part of the resident's plan of care. The RD did a quarterly nutrition assessment in March, 2014 where it was noted that that the resident was to receive high fibre juice at breakfast. This intervention however, was not re-assessed by the RD and as confirmed by the FSM on April 28, 2104 the high fiber juice was included in the resident daily fluid totals and was not tracked separately. The resident was noted to receive bowel medication thirteen times in the two weeks prior to this quarterly nutrition assessment.
It was also noted that this resident was at risk for dehydration. The MDS quarterly assessment completed by the RD in March, 2014 indicated that the resident needed ongoing assistance/encouragement re: adequate daily fluid intake due to cognitive impairment. The resident had not met their daily beverage target of 1125 ml/day on 39/50 (78%) days prior (January 28-March 18, 2014) to this assessment and this change in condition was not found to be assessed by the RD.
b) The MDS quarterly assessment for resident #102 was completed by the RD in February, 2014. Since that time (February 5-April 22, 2014), it was noted that the resident only met their calculated daily beverage target only on 4/76 days and therefore was below their target of 1275 ml/day 97% of the time. This significant change in the resident's health condition and risks related to nutrition care and hydration status were not assessed by the RD. [s. 26. (4)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that each resident of home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contradicted by a medical condition, in relation to the following: [33(1)]
Staff and clinical record documentation confirmed that four of six residents reviewed were not bathed twice a week. The Assistant Director of Care (ADOC) confirmed that residents #002, #005, #006 and #007 were not bathed twice during a one week period in April, 2014. The ADOC also confirmed there is not currently a system in place in the home to monitor residents bathing. [s. 33. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily and a between meal beverage in the morning.
a) On April 23, 2014 resident #102 was not offered the breakfast meal or a between meal beverage in the morning. This resident was not in the dining room for breakfast and was still in bed at 11:00 hours. The resident had a labelled 250 ml homo milk to be offered during the am snack pass. Staff confirmed that the resident was not offered the labelled milk for am snack as the resident was in bed. The resident was also not brought to the dining room for breakfast and therefore was not offered breakfast or the prescribed fibre orange juice. The resident was required physical assistance to manoeuvre into dining room. The resident was noted to be at high nutritional risk, had a low BMI and was at risk for dehydration.
b) It was observed and confirmed throughout the inspection that residents were not always offered a mid-morning beverage as the breakfast meal ran late and residents were still consuming the breakfast meal at 1045am. [s. 71. (3)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan or policy was complied with.
The home Interdisciplinary documentation policy LTC-D-20 dated August 2012 indicated that all documentation in the residents' health record would be accurate.
a) The plan of care for resident #103 indicated that the resident had received bowel medication eight times and a suppository four times in March, 2014. Section H of MDS was not completed and therefore a RAP was not triggered for the resident who experienced constipation during the 14 days prior to the assessment in March, 2014. Interview with the RAI coordinator/ADOC confirmed that the coding was done incorrectly as the resident experienced constipation during the last 14 days prior to the assessment and the resident's health record was not accurate.
b) Documentatiion in Point of Care (POC) computerized charting system was not found to be accurate. During the observed lunch meal on April 16, 2014,
i)resident #003 did not consume any of the 250 ml beverage, however, POC documentation indicated that the resident consumed 500 ml being consumed by the resident
ii)resident #105 consumed approximately 225 ml, however, POC documentation indicated that the resident consumed 650 ml being consumed by the resident
iii)resident #113 consumed approximately 3/4 of 250 ml, however, POC documentation was recorded as 550 ml being consumed by the resident
iv)resident #114 consumed 125 ml, however, POC documentation indicated that resident 350 ml was consumed [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 policies and procedures are complied with, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 68. (2)	CO #006	2013_202165_0010	156
O.Reg 79/10 s. 69.	CO #007	2013_202165_0010	156
O.Reg 79/10 s. 71. (4)	CO #009	2013_202165_0010	156

Issued on this 4th day of September, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	CAROL POLCZ (156), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2014_322156_0004
Log No. / Registre no:	H-000869-13/H-000870-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 12, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	TELFER PLACE 245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2013_202165_0010, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall ensure that the staff and others involved in the different aspects of care collaborate with each other in the assessment of hydration for all residents including residents #102 and #103 and physiotherapy assessment for all residents including resident #102 so that their assessments are integrated and are consistent with and complement each other; and in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Grounds / Motifs :

1. Previously issued as a CO June 6, 2013.
The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other.
1. Staff involved in the different aspects of care did not collaborate with each other in the assessment of hydration for the resident so that their assessments were consistent with each other.
a) The plan of care for resident #102 indicated that the resident was at high nutritional risk and at risk for inadequate fluid intake. The calculated target fluid intake requirement was 1700 ml/day and target beverage intake (based on 75% of the total fluid) was calculated to be 1275 ml/day. Nursing staff identified in the progress notes that the resident had not met their calculated daily fluid

requirement for three consecutive days on ten separate occasions from to March 1-April 22, 2014. The Registered Dietitian confirmed during interview on April 23, 2014, that a referral to dietary was not sent regarding the resident's hydration status . A review of the fluid intake flow-sheet, indicated that the resident had not met their daily target beverage intake of 1275 ml/day on 49/53 days or 92% of the time from March 1-April 22, 2014. The staff failed to collaborate with each other in the assessment of hydration of this resident and the assessment was not integrated and consistent with each other.

b) The plan of care for resident #103 indicated that the resident was at moderate nutritional risk and at risk for hydration due to poor fluid intake. The calculated fluid intake was a minimum of 1500 ml/day and target daily beverage intake was 1125 based on 75% of total fluid intake. Nursing staff identified in the progress notes that the resident had not met their calculated daily fluid requirement for three consecutive days on four separate occasions from March 1- April 23, 2014. The Registered Dietitian confirmed during interview on April 23, 2014, that a referral to dietary was not sent regarding the resident's hydration status. A review of the fluid intake flow-sheets indicated that the resident had not met their daily target beverage intake of 1125 ml/day on 32/54 or 55% of the time from March 1-April 23, 2014. The staff failed to collaborate with each other in the assessment of hydration of this resident and the assessment was not integrated and consistent with each other.

2. Nursing staff confirmed that they did not collaborate with physiotherapy staff in the assessment of resident #102 related to the risk of falling and falls.

a) Resident #102 was identified at high risk for falling when nursing staff completed a falls risk assessment in May, 2013. Nursing staff confirmed that they did not seek the collaboration of physiotherapy staff in the completion of this risk assessment. Risk factors identified by nursing on this assessment, including confusion, resident non- compliance as well as anti-anxiety and laxative medication were not considered in the assessments completed by physiotherapy staff.

Staff and clinical records confirmed that this resident fell in December, 2013, and on two occasions in April, 2014. The resident was assessed after these falls; however the circumstances that lead to the above noted falls were not incorporated into the Resident Assessment Protocols (RAPs) completed in August, and November, 2013 and February, 2014 and the care for the resident was not changed to reflect the circumstances causing the resident to fall. Nursing staff confirmed that they did not seek the collaboration of physiotherapy staff in the collection of data or the completion of the Resident Assessment Protocol (RAP) related to falling when the above noted assessments were

completed.
Physiotherapy staff completed three quarterly assessments for this resident dated August and November, 2013 and February, 2014 and nursing staff confirmed that they did not collaborate with physiotherapy staff in completing these assessments. Other factors identified by physiotherapy staff on these assessments were not incorporated into assessments completed by nursing over the same time period and the care directions identified for staff in managing the risk of falling did not include these factors identified in physiotherapy assessments. Nursing staff confirmed that each discipline completes their own assessments of the residents and they did not discuss the results of their assessments.
(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2013_202165_0010, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to all residents as specified in their plans.

Grounds / Motifs :

1. Previously issued as a CO June 6, 2013.
The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in their plans of care.
a) The plan of care dietary serving notes indicated that resident #104 disliked milk and water to drink at meals, however, was provided these during the observed lunch meal on April 16, 2014.
b) The plan of care dietary serving notes indicated that resident #105 disliked water to drink at meals, however, was provided water during the observed lunch meal on April 22, 2015. Notes also indicated that the resident was to be provided with crustless bread for sandwiches and toast, however, the resident received regular bread with crust on the sandwich on this date.
c) The plan of care dietary serving notes for resident #106 indicated that the resident was to be provided with small portions, however, was observed receiving regular portions on April 16 and 22, 2014.
d) The plan of care dietary serving notes for resident #001 indicated that the resident disliked milk to drink at meals, however, was provided milk to drink during the observed lunch meal on April 16, 2014.
e) The plan of care nourishment serving notes for resident #107 indicated that the resident was to be provided with assorted gelatin during the morning (am) nourishment. The resident was not provided this during the observed nourishment pass on April 16, 2014.

f) The plan of care nourishment serving notes for resident #108 indicated that the resident was to be provided with 100g vanilla yogurt during the am nourishment. The resident was not provided this during the observed nourishment pass on April 16, 2014.
g) The plan of care nourishment serving notes for resident #109 indicated that the resident was to be provided with vanilla pudding cup during the am nourishment. This was not available and therefore the resident was not provided this during the observed nourishment pass on April 16, 2014
h) The plan of care for resident #111 indicated that the resident attends the late breakfast, however, the it also indicated that the resident eats better when hot entrees are provided at meals as opposed to cold entrees. The resident was observed on April 22, 2014 in the main dining room at 10:30 hours being provided a muffin and banana for breakfast.
i) The plan of care indicated that resident #110 preferred to wake around 08:00 hours and have a hot breakfast. On April 22, 2014, it was noted that the resident received the continental breakfast and was observed at 10:30 hours in the main dining room being provided with a yogurt and puree Danish.
j) The plan of care for resident #001 directed that the resident's call bell was to be secured to the side rail as an intervention to manage a high risk for falling. On April 15, 2014 at 1420hrs the resident was interviewed and it was noted the call bell was wrapped around a mirror hanging on the wall at the head of the bed. Although the resident attempted to reach the call bell, it was demonstrated that the position of the call bell prevented the resident from reaching the call bell to call for assistance.
k) Resident #002 was not provided with care as specified in the plan of care. The plan of care for resident #002 directed that the resident was to be assisted to the toilet after meals. On April 16, 2014 the resident was moved into the lounge after lunch without being toileted. The Personal Support Worker (PSW) providing care to the resident was approached at 1400hrs and indicated that the resident was not toileted after lunch because other residents required care. This PSW also confirmed that the resident can be resistive to care and should be assisted to the toilet immediately when exiting the dining room.
l) The plan of care for resident #003 directed that the resident was to have a specified treatment to a specified limb continuously and the limb was to be elevated whenever possible in order to manage a risk of altered skin integrity related to edema. On April 15, 2014 at 1620hrs the resident was noted to be sitting in a wheelchair and did not have the treatment applied and the limb was not elevated. The registered staff confirmed that the treatment was not applied and the resident's wheelchair was not adapted to allow for the resident's limb to

be elevated. The registered staff confirmed that there was not a strategy in place to ensure that the resident's limb could be elevated while sitting in the wheelchair and that this resident would spend a significant amount of each day sitting in the wheelchair. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2013_202165_0010, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8,
s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Order / Ordre :

The licensee shall ensure that there is an organized program of nutrition care, dietary services and hydration for the home to meet the daily nutrition and hydration needs of all residents. The home shall ensure that there is an organized breakfast meal service which allows enough time between breakfast and lunch to ensure that all residents are offered breakfast, an am nourishment and lunch.

Grounds / Motifs :

1. Previously issued as a CO June 6, 2013.
The licensee failed to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents and an organized program of hydration for the home to meet the hydration needs of the residents.
The breakfast meal service extended from 08:00 hours until 11:00 hours during the inspection and staff confirmed that this was the regular practice of the home. The home had a hot breakfast meal service beginning at 08:00 hours which was available until 09:30 hours. The FSM confirmed that the morning snack menu was also the continental breakfast menu which consisted of yogurt or cheese with a muffin, scone or Danish There were a number of residents noted to be on the late breakfast (continental) plan, however, because several of these residents required assistance, these residents were not given an opportunity for

a hot breakfast. The residents who were offered the continental breakfast were not provided with the am snack because of proximity of time and closeness to the lunch meal.
On April 23, 2014 the morning snack cart was observed in the main dining room at 11:15. The nourishment pass was complete and the cart was ready to be emptied. It was noted that there were two labelled beverages which were not distributed and remained on the cart: a labelled 250 ml whole milk for resident #102 and 250 ml apple juice for resident #103.
a) Interview with front line staff indicated that resident #102 was not in the dining room for breakfast and was still in bed at 11:00 hours. As a result, the resident was not offered the labelled milk for am snack. Staff indicated that the resident was provided with a bath and then taken to lunch shortly thereafter. The resident was not provided with the labelled milk for am snack and also was not brought to the dining room for breakfast and therefore missed the ordered fibre orange juice as well. The resident was required physical assistance to manoeuvre into dining room. The resident was noted to be at high nutritional risk, had a low Body Mass Index (BMI) and was at risk for dehydration. The home did not have an organized program of hydration to ensure the resident received said beverages in the event of missing breakfast or am snack. The resident was noted to not have met their calculated daily beverage target on 49/53 days or 92% of the time from March 1-April 22, 2014.
b) Interview with staff confirmed that resident #103 refused the labelled juice at am snack as the resident was not in the dining room until after 09:15 hours, and took a long time to eat the breakfast. By the time the resident finished eating breakfast and consuming two beverages during that time, the resident refused the snack beverage. The home did not have an organized program of hydration to ensure the resident was offered the juice at a later time. The resident was noted to be at moderate nutritional risk at risk for dehydration and was noted to have not met their calculated daily beverage target on 32/54 or 55% of the time from March 1-April 23, 2014.
Interview with two staff during the nourishment pass on April 16, 2014 confirmed that since the pass did not start until late, it often was too close to lunch and therefore, residents did not want to eat or drink at snack time. The FSM and RD confirmed on April 23, 2014 that there was no system in place to ensure that residents received their prescribed fluids at a later time if it was missed during the breakfast or snack pass and therefore, ensure that the hydration needs of the residents were met. (156)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2013_202165_0010, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee shall ensure that a Registered Dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents whenever there is a significant change in a resident's health condition and assesses the nutrition status including risks related to constipation and hydration.

Grounds / Motifs :

1. Previously issued as a CO June 6, 2013.
The licensee failed to ensure that a Registered Dietitian who is a member of the staff of the home completes a nutritional assessment for all residents when there is a significant change in a resident's health condition and assesses the nutrition status including risks related to nutrition care and hydration status.
a) A review of the plan of care for resident #103 indicated that the resident was administered bowel medication 29 times and had their bowels disempacted during a two month period in 2014, however, constipation was not included on the resident's care plan. As confirmed by the RAI coordinator on April 24, 2014, this should have been part of the resident's plan of care. The RD did a quarterly nutrition assessment in March, 2014 where it was noted that that the resident was to receive high fibre juice at breakfast. This intervention however, was not re-assessed by the RD and as confirmed by the FSM on April 28, 2104 the high fiber juice was included in the resident daily fluid totals and was not tracked separately. The resident was noted to receive bowel medication thirteen times in the two weeks prior to this quarterly nutrition assessment.
It was also noted that this resident was at risk for dehydration. The MDS quarterly assessment completed by the RD in March, 2014 indicated that the resident needed ongoing assistance/encouragement re: adequate daily fluid intake due to cognitive impairment. The resident had not met their daily beverage target of 1125 ml/day on 39/50 (78%) days prior (January 28-March 18, 2014) to this assessment and this change in condition was not found to be assessed by the RD.
b) The MDS quarterly assessment for resident #102 was completed by the RD in February, 2014. Since that time (February 5-April 22, 2014), it was noted that the resident only met their calculated daily beverage target only on 4/76 days and therefore was below their target of 1275 ml/day or 97% of the time. This significant change in the resident's health condition and risks related to nutrition care and hydration status were not assessed by the RD. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2014_201167_0001, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents including residents #002, #005, #006 and #007 are bathed twice per week. The plan is to include but is not limited to: 1) the development and implementation of a system for monitoring resident's bathing in the home, and 2) The development and implementation of staff training related to alternate strategies to be implemented when a resident is not bathed on a scheduled bath day. The development and implementation of a process for monitoring staff performance in the monitoring of bathing and the implementation of alternate strategies identified above.

Grounds / Motifs :

1. Previously issued as a CO on June 6, 2013 and January 2, 2014.
The licensee did not ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contradicted by a medical condition, in relation to the following: [33(1)]
Staff and clinical record documentation confirmed that four of six residents reviewed were not bathed twice a week. The Assistant Director of Care (ADOC) confirmed that: resident #002, #005 , #006 and #007 were not bathed during a one week period in April 2014. The ADOC also confirmed there is not currently a system in place in the home to monitor residents bathing. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2013_202165_0010, CO #008;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that all residents including resident #102 are offered a minimum of three meals daily, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Grounds / Motifs :

1. Previously issued as a CO June 6, 2013.
The licensee failed to ensure that each resident was offered a minimum of three meals daily and a between meal beverage in the morning.
a) On April 23, 2014 resident #102 was not offered the breakfast meal or a between meal beverage in the morning. This resident was not in the dining room for breakfast and was still in bed at 11:00 hours. The resident had a labelled 250 ml homo milk to be offered during the am snack pass. Staff confirmed that the resident was not offered the labelled milk for am snack as the resident was in bed. The resident was also not brought to the dining room for breakfast and therefore was not offered breakfast or the prescribed fibre orange juice. The resident was required physical assistance to manoeuvre into dining room. The resident was noted to be at high nutritional risk, had a low BMI and was at risk for dehydration.
b) It was observed and confirmed throughout the inspection that residents were not always offered a mid-morning beverage as the breakfast meal ran late and residents were still consuming the breakfast meal at 1045am. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 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.

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 12th day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

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