Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 23, 2018;	2017_555506_0025 (A1)	025114-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON 000 000

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH BRANTFORD ON N3R 7G5

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

LESLEY EDWARDS (506) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home asked for an extension on their compliance date from February 12, 2018 to March 23, 2018 to ensure best practices for medication management are implemented.

Issued on this 23 day of January 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

LESLEY EDWARDS (506) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 3, 6, 7, 8 and 9, 2017.

During this inspection the following inspections listed below were conducted concurrently:

Complaint

008445-17- related to abuse and neglect, personal support services and dining and snack services

Critical Incident

020453-17- related to fall prevention

Follow-up

019337-17- related to medication administration

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Staff Educator, Resident Assessment Instrument Co-ordinator (RAI), Corporate Nursing Consultant, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), Food Service Managers (FSM), students, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes, observed dining services, reviewed clinical records, policies and procedures, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Skin and Wound Care

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

9 WN(s)
8 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The licensee failed to ensure that face to face training activities the home was ordered to complete as part of the compliance order for O. Reg. 79/10, s. 131 (2) served on August 31, 2017, were completed prior to the identified date of compliance date of October 6, 2017.
The licensee was ordered to provide face to face training to all registered staff who administer medications related to the standards of practice for medication administration.

i) Resident #021 was not administered their prescribed medication in accordance with the directions specified by the resident's Physician. The resident's Physician ordered the resident to receive the medication at specified times. This drug order was last reviewed by the Physician on an identified date in July 2017, when the Physician ordered the medication to be continued. Registered Practical Nurse (RPN) #104 confirmed that the order had not been changed from the time the Physician reviewed the resident's medications on an identified date in July 2017 and the time of this inspection. Registered Nurse (RN) #101 confirmed that the resident had not received the dose of the drug scheduled to be administered to the resident on an identified date in October 2017, when they submitted a medication incident report on an identified date in October 2017, which indicated that while preparing the resident's medications remained in the medication administration pouch and the resident had not received the medication as specified by the resident's Physician on an identified date in October 2017.
ii) Resident #022 was not administered their prescribed medication in accordance with the directions specified by the resident's Physician. The resident's Physician ordered the resident to receive the medication at regular scheduled intervals, to assist in the management of responsive behaviours demonstrated by the resident. This drug order was last reviewed on an identified date in August 2017, when the

physician ordered the drug to be continued. The Medication Administration Record (MAR) directed that the medication was to be administered at specified. RPN #104 confirmed that the order had not been changed from the time the Physician reviewed the resident's medications on an identified date in August 2017, and the time of this inspection. RPN #115 confirmed that the resident had not received the dose of the drug scheduled to be administered at the specified time when they submitted a medication incident report on an identified date in October 2017, which indicated the schedule dose of the medication remained in the medication administration pouch and the resident had not received the medication as specified by the resident's Physician on an identified on date in October 2017. The DOC confirmed that when the registered staff responsible for not administering the medication was interviewed they indicated they did not know why they had not administered the medication.
iii) Resident #023 was not administered their prescribed medication in accordance with the directions specified by the resident's Physician. The resident's Physician ordered the resident to receive a specified dose of the drug daily at a specified time and documented this order on the Physician's Order Review record on an identified date in October 2017. The Physician changed the dosage amount of the medication. The DOC, ADOC and the Medication Administration record confirmed that resident #023 did not receive the new dosage amount of the medication on an identified date in October 2017, four days after the Physician had specified the resident was to receive the new dose of the medication.
[s. 131. (2)]

Additional Required Actions:

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

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

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or substitute decision-maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #004 expressed concerns to the Long Term Care (LTC) homes Inspector that they were not being offered to use a specified medical device for their toileting needs and are having to use another device at all times and their wish would be to use the specified medical device for their toileting needs. There was no specified medical device found in the resident's room and staff informed the LTC homes Inspector there was a specified device in the spa room but it was not convenient or easily accessible. In an interview with PSW staff #105, #108 and #118 all confirmed that the resident was toileted by a device and was not offered the use of the specified medical device prior to toileting. PSW #109 confirmed that the resident was toileted by a medical device but does recall conversation about the specified medical device but the medical device was not in the resident's room to use. In an interview with the ADOC on an identified date in November 2017, they

confirmed that the resident was capable of making these decisions prior to toileting. The licensee failed to ensure that the resident was given the opportunity to participate fully in the implementation of their care. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in their plan.

Resident #005's plan of care directed staff to apply a medical device to the resident's wheelchair while up in their wheelchair to mitigate the risk of falls. A review of the clinical record confirmed resident #005 did not have their medical device applied to their wheelchair when they fell on an identified date in July 2017, as it was found in the resident's bed. An interview with RPN #122 on an identified date in November 2017, confirmed that the planned care for resident #005 was not provided as specified in their plan as the medical device was not applied to the resident's wheelchair to help mitigate the resident's fall. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

The care plan in effect for resident #005 in June 2017, confirmed that the resident was at high risk for falls since admission due to the resident forgetting to use aids, impaired cognition and responsive behaviours. Interventions included in the care plan were to ensure a medical device was in place while in bed and in wheelchair, remind resident to use transfer aides, call bell and light cord within reach and post fall huddles will be completed whenever necessary.

i. Resident #005 sustained an unwitnessed fall on an identified date in June 2017, with no injury.
ii.Resident #005 sustained an unwitnessed fall on an identified date in July 2017 and sustained an injury.
iii.Resident #005 sustained two unwitnessed falls on another identified date in July, 2017, approximately one hour apart where the resident complained of a pain from the first fall and a reddened area from the second fall.
iv.Resident #005 sustained an unwitnessed fall on another identified date in July, 2017, with no injury.
v.Resident #005 sustained an unwitnessed fall on an identified date in August 2017, where the resident sustained an injury.

A clinical record review confirmed that the care plan was not revised when the care set out in the plan had not been effective after each of the falls leading to the injury on an identified date in August 2017, In an interview with the DOC on an identified date in November 2017, they confirmed that it is the registered staffs responsibility to review and revise the residents' plan of care after each fall incident when completing the post fall assessment or post fall huddle. The DOC also confirmed that the resident was discussed at post fall huddles but not for this time period specified and confirmed resident #005's plan of care was not revised when the care in the plan was not effective in mitigating the resident's risk of falls.
[s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident, the resident's SDM are given the opportunity to participate in the residents plan of care, to ensure that the planned care is provided to the resident and to ensure when the plan of care has not been effective the plan of care is reviewed and revised, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Ontario Regulation (O. Reg) 79/10, s. 48. (1) required every licensee of a long term care home to ensure that the following interdisciplinary programs were developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's program, "Fall Prevention and Injury" (last revised August 31, 2016) stated that for all falls, a clinical assessment is completed and documented every shift for a minimum of 72 hours.

i) On an identified date in October 2017, resident #003 experienced an unwitnessed fall. A review of the clinical record only included a clinical assessment of the resident for three shifts out of the nine shifts that a clinical assessment should have been completed. Interview with the DOC on an identified date on November 2017, confirmed that the staff are not following the home's Fall Prevention and Injury policy.
ii) On an identified date in September 2017, resident #011 experienced an unwitnessed fall. A review of the clinical record only included a clinical assessment of the resident for six out of the nine shifts that the clinical assessment should have been completed. Interview with the DOC on an identified date on November 2017, confirmed that the staff are not following the home's Fall Prevention and Injury policy.

[s. 8. (1) (b)]

2. The licensee failed to ensure 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, is complied with.

1. In accordance with O. Reg. 79/10, s. 114(2) the licensee is to ensure that written policies and protocols are developed for the medication management system.

The licensee failed to ensure the policy "LTC- Medication Incidents", identified as CAR13-030.01 and last reviewed on August 31, 2016, was complied with. The licensee's policy included a tool identified as "LTC-Medication Incident Report". This policy directed that:
i) The individual discovering the incident will initiate a Medication Incident Report and enter it into Risk Management.
a) Staff did not comply with this direction when a Medication Incident Report (MIR) was not initiated and the incident involving resident #023 was not entered into Risk Management. The DOC, ADOC and clinical records confirmed that resident #023 was not administered a medication as specified by the resident's physician on identified dates in October 2017 and a MIR was not initiated nor was this information entered into Risk Management.
b) Staff did not comply with this direction when the Medication Incident Report identified as a tool in the licensee's policy was not initiated following a medication incident involving resident #022. The DOC and information provided by the home confirmed that on an identified date in October 2017, resident #022 was not administered their medication, in accordance with the directions specified by the resident's physician and the Medication Incident Report identified in the above noted policy was not initiated for this medication incident.

ii) For all resident-related medication incidents, there will be a brief factual description of the incident, treatment, and interventions documented in the interdisciplinary progress notes.

Staff did not comply with this direction when clinical records and documents provided by the home confirmed that there was no notations made in interdisciplinary progress notes for a medication incident that occurred on an identified date in September 2017, involving resident #020, a medication incident

that occurred on an identified date in October 2017, involving resident #021, a medication incident that occurred on an identified date in October 2017, involving resident #022 or a medication incident that occurred on identified dates in October, 2017 that involved resident #023.

iii) The Substitute Decision Maker (SDM)/Family will be notified of all resident related incidents.

Staff did not comply with this direction when clinical records and documents provided by the home confirmed that resident #020's SDM was not notified of the medication incident that occurred on an identified date in September 2017, resident #022's SMD was not notified of the medication incident that occurred on an identified date in October 2017 and resident #023 or their SDM were not notified of a medication incident that occurred on an identified dates in October 2017.

2. In accordance with O. Reg. 79/10, s. 127 the licensee shall ensure that a policy is developed to govern changes in the administration of drugs due to modifications of directions for use made by the prescriber including temporary discontinuation.

The licensee failed to ensure the policy "Change of Directions (COD) of Administration of Medications", located in the Nursing Staff section-MediSystem Pharmacy Policy and Procedure Manual and provided by the home, was complied with. This policy directed when a change of direction for the administration of medication occurs staff are responsible to locate the drug product and apply a "Change of Direction" auxiliary label.
During observations of medication administration made by the Long Term Care Homes (LTCH) Inspector on an identified date on November 2017, it was noted that the directions for use of a specified medication for resident #023 had changed; however the directions on the device in the medication cart were not identified as changed for resident #023. RPN #107, who administered the medication, confirmed that they were aware that the directions for use of this medication had changed on an identified date in October 2017. RPN #107 confirmed that the licensee's policy had not been complied with when, at the time of this inspection, "Change of Direction" labels had not been applied to the device for resident #107. [s. 8. (1) (b)]

3. The licensee failed to ensure that the home's weight and height monitoring policy was complied with.

The home's policy Nutritional Care and Hydration Weight and Height Monitoring (policy number CARE7-O10.03 last reviewed July 31, 2016) as required under the nutrition and hydration program Regulation 68 (2) (a), directed staff to weigh residents and document the weight by the 7th day of each month. If a weight loss or gain was 2.0 kilogram (kg) or greater from the preceding month, staff were to immediately confirm the weight.

i) Resident #006 was admitted to the home on an identified date in December 2016, with a weight recorded on an identified date in December 2016. The next weight was recorded on an identified date in January 2017, which represented a weight change of greater than 2 kg. The initial assessment completed by the RD on an identified date in January 2017, indicated that the resident's "weight is within healthy range and likely not decreased significantly the past month therefore suspect inaccurate weight". The weight was not confirmed as per policy as the resident was not reweighed as confirmed with the DOC on an identified date in November 2017.
ii) The weight recorded on an identified date in January 2017, and on an identified date in February 2017, which represented a weight change of greater than 2 kg. The weight was not confirmed as per policy as the resident was not reweighed as confirmed with the DOC on an identified date in November 2017.
iii) The weight recorded on identified date in February 2017, and on an identified date in March 2017, which represented a weight change of greater than 2 kg. The weight was not confirmed as per policy as the resident was not reweighed as confirmed with the DOC on an identified date in November 2017.
iv) The weight recorded on an identified date in September 2017, and on an identified date in October 2017, which represented a weight change of greater than 2 kg. The weight was not confirmed as per policy as the resident was not reweighed as confirmed with the DOC on an identified date in November 2017. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's policies and procedures are followed for falls, medication management and nutritional care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The home had a policy in their Administration manual under the section Safety and Security, titled Medical Devices and Equipment, last revised July 31, 2016, which indicated that when using medical devices and equipment that all devices and or equipment would be checked before use. The LTC homes Inspector confirmed on an identified date in November 2017, with the home's DOC that this policy would include the use of the personal medical devices and it was the expectation that these devices be checked to ensure they were in good working order prior to each use.
A. A review of resident #005's clinical record identified that the resident sustained a fall near their room on an identified date in October 2017. The resident's personal medical device did not sound and the resident sustained an injury. RN #106 confirmed on an identified date in November 2017, that the personal medical device was not in a good state of repair was replaced after the resident fell.
B. A review of resident #011's clinical record identified that the resident sustained an unwitnessed fall on an identified date on September 15, 2017. The resident fell in their room and the resident's personal medical device did not sound. The DOC confirmed on an identified date in November 2017, that the personal medical device was not in a good state of repair and was replaced after the resident fell. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

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 the plan of care was based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration.

Resident #001 had a care plan in place that did not include an assessment of the resident's hydration status or any risks related to hydration. The resident was transferred to hospital on an identified date in August 2017, with specific diagnosis. The resident was treated and the resident returned to the home on an identified date in September 2017, however; at the time of the inspection, risks for dehydration were not found to be part of the resident's plan of care. There were no interventions put in place to increase fluids or assess any risks related to hydration for this resident as confirmed with the DOC on an identified date in November 2017. [s. 26. (3) 14.]

2. The licensee failed to ensure that the plan of care included resident #007 skin conditions, including altered skin integrity.

Resident #007 had a Physician's order that directed staff to check the resident's skin daily and apply a treatment. The Minimum Data Set (MDS) dated September 2017, also indicated that the resident had altered skin integrity. A care plan was not in place to address the resident's skin condition. RN #101 confirmed that this information was not included in the resident's care plan and should have been as the resident was receiving treatment. [s. 26. (3) 15.]

3. The licensee failed to ensure that the registered dietitian (RD) who was a member of the staff of the home: completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition.

Resident #006 was admitted to the home on an identified date in December 2016. An initial nutritional assessment was opened by the Registered Dietitian in the home's computer software program, point click care, however was found to be blank and still was listed as "in progress" at the time of the inspection. The resident's care plan did not address nutritional risk level and the initial nutritional assessment was not completed by the RD until an identified date in January 2017, which was six weeks after admission. The DOC confirmed that it was the expectation of the home that the initial nutritional assessment was to be completed by the RD within 14 days of admission and that the registered dietitian who was a member of the staff of the home failed to complete a nutritional assessment for the resident on admission. [s. 26. (4) (a),s. 26. (4) (b)]

4. The licensee failed to ensure that the registered dietitian who was a member of the staff of the home a) completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition; and (b) assess the resident's nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration

Resident #001 was transferred to hospital on an identified date in August 2017, with specified diagnosis. The resident was treated with intervention and the resident returned to the home on an identified date in September 2017. The resident was seen by the RD on an identified date in September 2017, in reference to a previously submitted referral for altered skin integrity, however, was not assessed for their change in health condition. Risks related to hydration and hydration status were not assessed by the RD as confirmed with the DOC on an

identified date in November 2017. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents at risk of hydration have a care plan with associate risks identified and all residents are assessed by the dietitian on admission or when there is a significant change in condition and to ensure resident's with altered skin integrity have a care plan in place, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status

Resident #006 was admitted to the home on an identified date in December 2016, with a weight recorded on an identified date in December 2016. The next weight recorded for January, 2017, which represented a weight change of greater than five per cent over one month. The resident's weight change was not assessed.
The initial assessment completed by the RD on an identified date in January 2017, only indicated that the resident's "weight was within healthy range and likely not decreased significantly in the past month therefore suspect inaccurate weight".
There was no assessment of the resident's weight change as confirmed with the DOC on an identified date in November 2017.
The following month, in February, 2017, the weight was recorded which represented a weight change of greater than five per cent over one month when compared to the January weight. The weight change was not assessed as confirmed with the DOC on an identified date in November 2017.
The weight recorded in April, 2017, which represented a weight change of greater than 7.5 per cent over three months when compared to the January weight. The weight change was not assessed as confirmed with the DOC on an identified date in November 2017.
[s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or medication cart that is secure and locked.

Staff did not ensure that drugs were stored in an area or medication cart that was secured and locked when during a tour of the home on an identified date in November 2017, it was noted that the treatment cart stored in the hall of the 300 Wing was unlocked. Several residents and staff were moving in the hall at the time of this observation as the meal had just concluded. The ADOC passed by in the hall and they confirmed that it was the expectation that the treatment cart be locked at all times when not attended by a registered staff member. A review of the contents of the treatment cart confirmed that the cart contained prescription treatment creams, ointments and topical sprays that had identified Drug Information Numbers (DIN) both on the labels and the containers. The licensee failed to ensure that drugs were stored in an area or medication care that was secured and locked.[s. 129. (1) (a) (ii)]

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 drugs were stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

i) On an identified date on September 2017, resident #020 was not provided with a medication ordered by their Physician. A MIR, provided by the home, confirmed that on the identified date the resident did not receive a scheduled dose of medication. There was no indication in the resident's clinical record or on the MIR that the resident or the resident's SDM were notified of the medication incident that occurred on an identified date in September 2017.
ii) On an identified date in October 2017, resident #022 was not provided with a medication ordered by their Physician. A MIR, provided by the home, confirmed that on the identified date the resident did not receive a scheduled dose of medication. The MIR indicated "ask afternoon staff to follow-up with family". There was no indication in the resident's clinical record or the MIR that the resident's SDM was notified of the medication incident that occurred on an identified date in October 2017.
iii) On identified dates in October 2017, resident #023 was not provided with a medication as specified by their Physician. The DOC, ADOC, Medication Administration Record (MAR) and the Physician's Order Review form confirmed that the resident's physician ordered the resident a dose of a specified medication at a specified time. The MAR confirmed that the medication was not administered to the resident for four days after the physician order was made. The DOC confirmed that a MIR was not completed in relation to this incident.
[s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were reviewed, analyzed and corrective action was taken as necessary.

i) The home provided a MIR that indicated resident #021 had not received a medication that was ordered by the resident's Physician on an identified date in October 2017. A review of the MIR confirmed that there was not a review of the incident or the circumstances that lead to the incident and there was no analysis of this incident. The DOC confirmed there was no other documentation related to this medication incident at the time of this inspection.
ii) The home provided a MIR that indicated resident #022 had not received a medication that was ordered by the resident's Physician on an identified date in October 2017. A review of the MIR confirmed that there was not a review of the incident or the circumstances that lead to the incident nor was the incident analyzed to determine what if any corrective action might be appropriate to prevent a recurrence. The DOC confirmed there was no other documentation related to this medication incident at the time of this inspection. [s. 135. (2)]

3. The licensee failed to ensure that a written record was kept of the quarterly medication incident review.

The DOC confirmed that the quarterly review of medication incidents would occur during the Professional Advisory Committee (PAC) meetings that were held on a quarterly basis. Minutes of the PAC meeting held on an identified date in September 2017, were provided. A review of the minutes of this meeting confirmed that there were no minutes recorded that would indicate the medication incidents over the last three months had been reviewed at the meeting. A chart that gave a brief outline of the medication incidents that occurred between June 2017 and August 2017 was included with the minutes provided. The chart indicated there were 12 medication incidents during the above noted period of time and all of the incidents resulted in residents not receiving the medication as was specified in the Physician’s orders. The DOC made a handwritten note on the back of the third page of the minutes indicating that they meet with the Pharmacist, discussed medication incidents. The DOC confirmed that the hand written note did not record the discussions that were held. The DOC confirmed that there was no other documentation related to the review of medication incidents during the period of the review. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; to ensure that all medication incidents and adverse drug reactions were reviewed, analyzed and corrective action was taken as necessary and to ensure that a written record was kept of the quarterly medication incident review, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program.

The ADOC confirmed that the following issues were part of the Infection Prevention and Control program in the home:

i) The ADOC confirmed that personal care items were to be labelled with the name of the resident, not used for multiple residents and stored in a way that would prevent contamination.
Staff did not participate in the implementation of the Infection Prevention and Control program, when it was observed on an identified date in November 2017, during a tour of the home, that two used unlabelled stick deodorant containers, two used unlabelled personal care products (skin cream and shimmering body powder) and a slipper bedpan were stored on the floor of the spa room in the 300 wing. The ADOC confirmed that the skin cream and the shimmering body powder were a

resident's personal belongings and it was the expectations that personal products would be labelled, not used for multiple residents and stored appropriately off the floor.
ii) The ADOC confirmed and the licensee's Routine Practices and Additional Practices Infection Control policy directed that "precaution signage was to be visible on entry to the room. Resident rooms #411, #304, #312 and #313 were noted to have yellow infection control caddies hanging on the doors to those rooms. The ADOC confirmed that staff had not participated in the implementation of the Infection Prevention and Control program when it was confirmed that precaution signage was not posted on entry to those rooms.
iii) The ADOC and PSW#123 confirmed that staff were to dispose of soiled Personal Protective Equipment (PPE) in the black garbage containers that were positioned in the hallway outside resident rooms. The ADOC confirmed that staff had not participated in the implementation of the Infection Prevention and Control program when it was confirmed that garbage containers for soiled PPE were not in the vicinity of five rooms that were identified as rooms where a resident had an infection that required the use of PPE.
iv) The ADOC confirmed that when more than one resident was in a room, a blue sticker was placed beside the name of the resident who required the use of additional precautions and PPE. The ADOC confirmed that staff had not participated in the implementation of the Infection Prevention and Control Program when blue stickers were not in place on the name plate outside three resident rooms that had yellow infection control caddies on the doors to those rooms and contained more than one resident. On an identified date in November 2017, LTC Homes Inspector #506 interviewed PSW #119 who confirmed they did not know which resident in the room required additional precautions and the use of PPE. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

Issued on this 23 day of January 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LESLEY EDWARDS (506) - (A1)

Inspection No. / No de l'inspection : 2017_555506_0025 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 025114-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Jan 23, 2018;(A1)

Licensee / Titulaire de permis : REVERA LONG TERM CARE INC.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000

LTC Home / Foyer de SLD : BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Debbie Boakes

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To REVERA LONG TERM CARE 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_205129_0015, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

1. The licensee shall ensure that drugs are administered to residents, including resident # 021, resident #022 and resident #023 in accordance with the directions for use specified by the prescriber.
2. The licensee is to require that all registered staff who administer medication review the College of Nurses of Ontario "Medication Administration Standards of Practice" guidelines. Staff are to be questioned in relation the barriers to fully implementing the above noted standards and action is to be taken to address any barriers identified. Documentation of these activities will be maintained by the home.
3. The licensee shall review the Institute for Safe Medication Practices Canada "Canadian Medication Incident Reporting and Analysis" document. The licensee shall determine what concepts from the above noted review will be incorporated into in the risk management program and in the quality improvement and utilization system of the home.

Grounds / Motifs :

1. This order is based on the application of the factors of severity (2), scope (3) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of the potential for harm for the identified residents, the scope of widespread

and the licensee's history of non-compliance that included: voluntary plans of corrective action (VPC) issued in May 2016 and a compliance order (CO) issued in August 2017.

The licensee failed to ensure that face to face training activities the home was ordered to complete as part of the compliance order for O. Reg. 79/10, s. 131 (2) served on August 31, 2017, were completed prior to the identified date of compliance date of October 6, 2017.
The licensee was ordered to provide face to face training to all registered staff who administer medications related to the standards of practice for medication administration.

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

i) Resident #021 was not administered their prescribed medication in accordance with the directions specified by the resident's Physician. The resident's Physician ordered the resident to receive the medication at specified times. This drug order was last reviewed by the Physician on an identified date in July 2017, when the Physician ordered the medication to be continued. Registered Practical Nurse (RPN) #104 confirmed that the order had not been changed from the time the Physician reviewed the resident's medications on an identified date in July 2017 and the time of this inspection. Registered Nurse (RN) #101 confirmed that the resident had not received the dose of the drug scheduled to be administered to the resident on an identified date in October 2017, when they submitted a medication incident report on an identified date in October 2017, which indicated that while preparing the resident's medications remained in the medication administration pouch and the resident had not received the medication as specified by the resident's Physician on an identified date in October 2017.
ii) Resident #022 was not administered their prescribed medication in accordance with the directions specified by the resident's Physician. The resident's Physician ordered the resident to receive the medication at regular scheduled intervals, to assist in the management of responsive behaviours demonstrated by the resident. This drug order was last reviewed on an identified date in August 2017, when the physician ordered the drug to be continued. The Medication Administration Record (MAR) directed that the medication was to be administered at specified. RPN #104 confirmed that the order had not been changed from the time the Physician reviewed the resident's medications on an identified date in August 2017, and the time of this

inspection. RPN #115 confirmed that the resident had not received the dose of the drug scheduled to be administered at the specified time when they submitted a medication incident report on an identified date in October 2017, which indicated the schedule dose of the medication remained in the medication administration pouch and the resident had not received the medication as specified by the resident's Physician on an identified on date in October 2017. The DOC confirmed that when the registered staff responsible for not administering the medication was interviewed they indicated they did not know why they had not administered the medication.
iii) Resident #023 was not administered their prescribed medication in accordance with the directions specified by the resident's Physician. The resident's Physician ordered the resident to receive a specified dose of the drug daily at a specified time and documented this order on the Physician's Order Review record on an identified date in October 2017. The Physician changed the dosage amount of the medication. The DOC, ADOC and the Medication Administration record confirmed that resident #023 did not receive the new dosage amount of the medication on an identified date in October 2017, four days after the Physician had specified the resident was to receive the new dose of the medication.
(129)

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

Mar 23, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 23 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LESLEY EDWARDS - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : Hamilton