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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 30, 2017	2016_168202_0022	033034-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

YORK REGION NEWMARKET HEALTH CENTRE
194 EAGLE STREET NEWMARKET ON L3Y 1J6

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

VALERIE JOHNSTON (202), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 24, 25, 28, 29, 30, December 01, 02, 2016.

During the course of the inspection the following intakes were completed:

-Complaint #003580-14 related to the rejection of a long term care home applicant for non-valid reasons and #001081-15 related to not responding within five days to the appropriate placement co-ordinator for a number of applications between January 01, 2014, to January 19, 2015.
-Critical Incident #015810-16, related to improper/incompetent treatment of resident that resulted in harm or risk of harm to a resident.

During the course of the inspection, the inspector(s): reviewed clinical records, conducted a tour of the home, reviewed home's policies related to continence care, skin and wound, resident abuse and neglect, reviewed staff education records and resident council meeting minutes.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Supervisors of Care (SOCs), Physiotherapist, Occupational Therapist, Registered Nursing Staff, Personal Support Workers, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

7 WN(s)
1 VPC(s)
3 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents are protected from abuse by anyone and free from neglect by the licensee or staff.

The home submitted an identified Critical Incident System (CIS) report in 2016, indicating that resident #016 had received improper/incompetent treatment that resulted in harm to the resident.

Resident #016 had been admitted to the home on an identified date in 2014. Resident #016's clinical records revealed that the resident had ongoing altered skin integrity since his/her admission. The resident required two staff total assistance for care, repositioning, and was incontinent.

A review of resident #016's progress notes from the time of his/her admission identified the resident to have periods of altered skin integrity to identified areas of the body that would heal and reopen. The notes specifically related to the CIS report for an identified date revealed the following:

-RN #102 had assessed resident #016's altered skin integrity and documented that the resident's altered skin integrity had improved over the past seven days and that the dressings have remained intact.

-RN #112 had assessed resident #016's altered skin integrity later the same day and documented that the resident's altered skin integrity had deteriorated and deemed unstageable. Only one dressing was found at the site of altered skin integrity and the area was heavily soiled.

Interviews with RN #112 and PSW #114 indicated that they had provided care to resident

#016 at an approximate identified time, on the identified date of assessment as indicated above, when he/she had been found in need of personal care. PSW #114 stated that the resident did not have any dressings in place and the skin condition of identified areas of the resident's body was in poor condition. Both staff indicated that they were shocked and surprised that the resident's skin had deteriorated as they had read and heard in shift report that the resident's skin had improved. PSW #114 indicated that the DOC was notified at the time of incident.

An interview with the DOC indicated that he/she assessed resident #016's skin upon receipt of the report from PSW #114. The DOC indicated that the resident's skin was found to be compromised and not indicative of the documentation previously reported. The DOC confirmed that immediate treatment was provided and the resident's deteriorated skin integrity was reported to the home's skin and wound care lead, Supervisor of Care (SOC) #104, for investigation.

An interview with SOC #104 indicated that during the home's investigation and review of resident #016's progress notes revealed that the resident's altered skin integrity should not have deteriorated so quickly. The SOC further indicated that he/she did not believe RN #102 assessed resident #016's identified area of altered skin integrity properly and during the home's investigation the RN confirmed that he/she did not assess resident #016's identified altered skin integrity area on the identified date, and documented that he/she had. The SOC confirmed that when RN #102 failed to assess the resident's identified altered skin integrity and falsified documentation in the progress notes, had subjected resident #016 to neglect. As a result of both the RN's actions and inactions, the resident did not receive appropriate assessment, treatment and care for his/her identified pressure wounds and as a result the resident's altered skin areas had deteriorated. The RN was disciplined.

An interview with RN #102 confirmed that on the above mentioned identified date, he/she did not assess resident #016's identified areas of skin integrity as scheduled. RN #102 further confirmed that he/she did not look resident #016's altered skin integrity and falsely documented an assessment of the resident's skin on what he/she had remembered the identified skin integrity area to have looked like several days earlier. The RN stated that as a result of his/her inactions, the resident did not receive the appropriate treatment or care that would have been required for the resident's skin and as a result the resident's already altered skin integrity had deteriorated substantially.

Interviews with the SOC, RN #102 and the Occupational Therapist (OT) confirmed that

on the following day of the identified date where resident #016's skin integrity had been found in a deteriorated state, resident #016's inflatable ROHO wheelchair cushion was found to be damaged and visibly over inflated on the one side. When asked as to the length of time the inflatable ROHO cushion had been in disrepair, the SOC indicated that there was no way of knowing how long the resident had been sitting in a compromised position while in his/her wheelchair. The SOC further indicated that resident #016's inflatable ROHO cushion had been found on his/her wheelchair underneath a cover which would have prevented staff from seeing the cushion and its actual condition. Both RN #102 and SOC #104 confirmed that the state of the resident's inflatable ROHO cushion would have contributed to the deterioration of resident #016's skin.

Interviews with the DOC, SOC #104 and RN #102, indicated that residents who require the use of an inflatable ROHO cushion while in their wheelchair are to be monitored by front line staff for the appropriate inflation at the time of each use. When asked if there was any way to confirm that staff were monitoring the inflation and state of an inflatable ROHO cushion, the DOC, SOC #104 and RN #102 stated that there was not, however, were confident the front line staff had monitored resident #016's inflatable ROHO cushion.

An interview with PSW #114 indicated that inflatable ROHO cushions are not always checked by front line staff for inflation prior to use. PSW #114 indicated that at the start of his/her shift he/she would often find residents sitting on under inflated or overinflated ROHO cushion and would have to go to each resident to fit them properly in their ROHO. PSW #114 indicated that he/she became frustrated with being the only staff member monitoring the inflatable ROHO cushions and stated that as of January 2016, he/she stopped checking. PSW #114 indicated that on the date for which resident #016 altered skin integrity had been found in a deteriorated state confirmed that the resident's inflatable ROHO cushion did appear to be low in air.

Interviews with RN #102, PSWs #103, and #114 indicated that they had only received formal training on November 03, 2016, of the proper fit of an inflatable ROHO cushion. Staff indicated that prior to this date; they would have been shown by the vendor on an as needed basis. SOC #104 confirmed in an interview that staff had received training November 03, 2016, on adjusting inflatable ROHO cushions and that there had been no formal training prior to this date.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #016 had been identified with ongoing altered skin integrity since his/her admission in 2014. On an identified date, RN #102 failed to assess resident #016's identified altered skin integrity, falsified documentation in the progress notes and as a result of both the RN's actions and inactions, the resident did not receive appropriate assessment, treatment and care for his/her identified altered skin integrity and as a result the resident's altered skin areas had deteriorated.

Additionally, on the day after finding resident #016's skin had deteriorated the resident's inflatable ROHO cushion used to prevent skin breakdown had been found damaged. The length of time that the resident had been placed on a compromised cushion is unknown and as staff indicated, may have been for some time. Staff indicated that the resident's inflatable ROHO cushion had not been monitored for appropriate inflation upon each use and formal training had not been provided to staff until November 03, 2016.

The scope of the non-compliance is isolated to resident #016. There is no previous non-compliance in this area of the legislation. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident be reassessed and the plan of care

reviewed and revised at least every six months and at any other time when, the resident's care needs have changed or care set out in the plan is no longer necessary.

The home submitted an identified Critical Incident System (CIS) report in 2016, indicating that resident #016 had received improper/incompetent treatment that resulted in harm to the resident.

Resident #016 had been admitted to the home on an identified date in 2014. Resident #016's clinical records revealed that the resident had ongoing altered skin integrity concerns since his/her admission and most notably to an identified area of the body. The resident required two staff total assistance for care, repositioning, and was incontinent.

A review of resident #016's progress notes indicated that on an identified date the ongoing altered skin integrity concerns had deteriorated.

Interviews with RN #102, PSWs #101, #103, and #114 confirmed that resident #016's skin had been found in a deteriorated condition on the above identified date and as an intervention to promote healing both the plan of care and the written plan of care had been updated to direct all staff to keep the resident in bed and up in his/her wheelchair for meals only. Both the day shift RN and PSW #103 indicated that the resident's identified altered skin integrity had healed and the resident no longer required to be placed in bed after lunch. The evening shift staff PSW #101 and #114, both indicated that the resident should be placed in bed after lunch as the resident's identified areas of altered skin integrity remained fragile. The current written plan of care directs staff to place the resident in bed after all meals.

On an identified date during the course of the inspection, the inspector had observed the resident to be sitting in his/her wheelchair outside his/her room door for an identified period of time. RPN #100, PSWs #101 and #114 confirmed that the resident had been sitting in this same position from the beginning of their shift. The staff indicated that the resident should have been put back to bed after lunch, as the resident's skin continues to be fragile and compromised. PSW #114 and #101 stated that the resident had not been put to bed after lunch for at least four to six weeks and that he/she continually finds the resident sitting in his/her wheelchair at the beginning of their shift.

At a time during the identified observation period above, both PSWs #114 and #101 provided care to resident #016 in his/her room and indicated that the resident visibly needed care and his/her identified fragile skin had deteriorated. PSWs #114 and #101

indicated that the resident should have been put to bed after lunch by the day shift staff.

The DOC was made aware of the resident's skin condition and that the resident may not have received care for an identified period of time during the observation period. The DOC investigated and confirmed the condition of the resident's skin as described above and had confirmed through the home's video surveillance that the resident had received care during the period of time by the day shift staff and had been placed back in his/her wheelchair at that time.

The DOC indicated that the care needs specific to the resident #016's skin integrity required reassessment. The DOC confirmed that the resident #016's care needs had not been reassessed and the resident's plan of care had not been updated to reflect his/her current condition. The DOC further indicated that a meeting had been planned with all staff working on the resident's home area to review and revise his/her plan of care.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

On an identified date, an area of resident #016's skin had been assessed by staff to have deteriorated substantially. As skin care intervention both the plan of care and the written plan of care had been updated to direct all staff to keep the resident in bed and up in his/her wheelchair for meals only. Current clinical records indicated that the resident's skin remained altered. Interviews with direct care staff from both the day shift and evening shift yielded conflicting skin integrity interventions for the resident. The actual care that resident #016 required had not been assessed and interventions provided by direct care staff had not been consistent which resulted in further skin deterioration. The DOC confirmed that the current care needs of resident #016 had not been reassessed or care plan reviewed and revised to reflect his/her current needs.

The scope of the non-compliance is isolated to resident #016. There is no previous non-compliance in this area of the legislation. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 had failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The home submitted an identified CIS report in 2016, indicating that resident #016 had received improper/incompetent treatment that resulted in harm to the resident. The CIS further indicated that resident #016's inflatable ROHO cushion had been found damaged and had been identified as a contributing factor in the resident's skin deterioration.

Resident #016 had been admitted to the home at a time in 2014. Resident #016's clinical records revealed that the resident had ongoing altered skin integrity since his/her admission specifically to an identified area. The resident had been assessed to use a wheelchair with inflatable ROHO cushion, two staff total assistance for care, repositioning, and was incontinent.

A review of resident #016's progress notes from the time of his/her admission identified the resident to have periods of altered skin integrity that would heal and reopen. The notes indicated that on an identified date the resident's skin had been found to have deteriorated.

Interviews with the SOC, RN #102 and the Occupational Therapist (OT) confirmed that on the day after finding that resident #016's skin had deteriorated, resident #016's inflatable ROHO cushion was found to be damaged and visibly over inflated on the one side. When asked as to the length of time the inflatable ROHO cushion had been in

disrepair, the SOC indicated that there was no way of knowing how long the resident had been sitting in a compromised position. The SOC further indicated that resident #016's inflatable ROHO cushion had been found on his/her wheelchair underneath a cover which had prevented staff from visualizing the cushions actual state. Both RN #102 and SOC #104 confirmed that the state of the resident's inflatable ROHO cushion had contributed to the deterioration of resident #016's identified altered skin integrity.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #016 had been identified with ongoing altered skin integrity since admission in 2014. On an identified date after the resident's skin had been found deteriorated the resident's inflatable ROHO cushion used to prevent skin breakdown had been found underneath a cover damaged. The length of time that the resident had been placed on a compromised cushion is unknown and as staff indicated that they had not visualized the ROHO cushion for some time. Staff indicated that the resident's inflatable ROHO cushion had not been monitored for appropriate inflation upon each use and formal training had not been provided to staff until November 03, 2016.

The scope of the non-compliance is isolated to resident #016. There is no previous non-compliance in this area of the legislation. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 003 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. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

s. 162. (5) The licensee shall give the appropriate notice under paragraph 1 or 2 of subsection (3) within three business days of receiving the additional information provided under subsection (4). O. Reg. 79/10, s. 162 (5).

Findings/Faits saillants :

1. The licensee had failed to ensure that subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following: 1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act.

On August 14, 2014, and January 20, 2015, the Ministry of Health received two complaints indicating that the licensee had rejected an application for non-valid reasons and the licensee had not responded within five days to the appropriate placement co-ordinator for a number of applications between January 01, 2014, to January 19, 2015.

A review of the Central Community Care Access Centre (CCAC) (Non Crisis) Outstanding by Facility list between March 01, 2014, and March 17, 2015, indicated that the licensee had not provided the placement co-ordinator written notice of approval or rejection for 31 applicants within five days as required.

Interviews with both the DOC and the Administrator confirmed that the home had not provided a written notice to the placement co-ordinator for the identified 31 applicants as mentioned above. The Administrator further indicated that the home receives approximately 25 applications per week from CCAC, and because the volume is so high, there are challenges to responding to CCAC within five days as required. [s. 162. (3) 1.]

2. The licensee shall give the appropriate notice under paragraph 1 or 2 of subsection (3) within three business days of receiving the additional information provided under subsection (4). O. Reg. 79/10, s. 162 (5).

On August 14, 2014, and January 20, 2015, the Ministry of Health received two complaints indicating that the licensee had rejected an application for non-valid reasons and the licensee had not responded within five days to the appropriate placement co-ordinator for a number of applications between January 01, 2014, to January 19, 2015.

On January 12, 2015, the CCAC, placement co-ordinator provided the home with a list of 51 applicants to be reviewed with the home's admissions committee for acceptance or rejection. A review of the list revealed that between November 14, 2014, to October 2015, the home had requested additional information for all 51 applicants from the placement co-ordinator. The list of information further revealed that the placement co-ordinator had responded to the home with the additional information and/or answers as requested, however, the documents indicated that the home had not responded.

Interviews with both the DOC and the Administrator confirmed receipt of the list and confirmed that the home had not responded or provided a written notice to the placement co-ordinator for the above mentioned 51 applications. [s. 162. (5)]

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 subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following: 1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions had been documented.

The home submitted an identified Critical Incident System (CIS) report in 2016, indicating that resident #016 had received improper/incompetent treatment that resulted in harm to the resident.

A review of the home's Skin and Wound Program, dated December 2013, and embedded policy #2, Repositioning of Residents, revised April 28, 2016, states "residents who are confined to a bed or recliner and are unable to shift or reposition themselves must be repositioned every two hours". In addition, "a task will be set up in Point of Care (Kardex) for direct staff to follow and to document when the task is completed".

Resident #016 had been admitted to the home at a time in 2014. Resident #016's clinical records revealed that the resident had ongoing skin integrity since his/her admission specifically to an identified area of the body. The resident required two staff total assistance for care, turning and repositioning, and was incontinent.

A review of resident #016's progress notes indicated that on an identified date the identified and ongoing skin integrity areas had deteriorated.

Interviews with RN #102, PSWs #101, #103, and #114 confirmed that resident #016's skin had deteriorated on the identified date and as an intervention to promote healing the resident was required to remain in bed, except for meals and required to be turned and repositioned every two hours by staff. Staff indicated that they documented in Point of Care (POC) when the resident had been repositioned within the defined and pre-set times on POC.

A review of resident #016's POC documentation from the time of identified altered skin deterioration to the current time revealed that staff had only documented when resident #016 had been repositioned between the hours of 1900 and 0500. An interview with SOC #115 confirmed that resident #016 was under the skin and wound care program and that the resident required staff assistance to be turned and repositioned every two hours. The SOC indicated that although staff would have turned and repositioned the resident, the task intervention in POC had not been set up to document every two hours and therefore, the resident's response to the turning and repositioning intervention had not been documented between 0700 and 1600 hours daily. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstance of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of

incontinence.

During stage one of the RQI, the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessments indicated resident #001 had continence decline between the 90-day and admission assessments.

A review of resident #001's the RAI-MDS assessments revealed the resident's bladder and bowel continence status had changed from usually continent on admission to frequently incontinent the next quarter.

The home uses a Bladder and Bowel Continence Assessment on Point Click Care (PCC) for the assessment of incontinence. Review of resident #001's assessment records indicated the resident had received a continence assessment on admission. The resident had not received a continence assessment after his/her continence status had changed to frequently incontinent three months later.

Interviews with the DOC, RPN #109 and PSW #105 indicated the resident's continence status had declined after he/she was admitted to the home and the resident had not received a continence assessment when he/she became frequently incontinent as required. [s. 51. (2) (a)]

2. The licensee has failed to ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment.

During stage one of the RQI, the RAI-MDS assessments indicated resident #001 had continence decline between the 90-day and admission assessments.

A review of resident #001's RAI-MDS assessments dated six months post admission revealed the resident was incontinent of bladder and frequently incontinent of bowel. The Resident Assessment Protocol (RAP) for the assessed time indicated the resident's cognitive status had declined and the resident was no longer able to ring the bell for assistance with toileting, and was therefore having increased incontinence of bladder.

Review of resident #001's plan of care indicated the resident had physical impairment and required one-person assistance for toileting. The plan of care did not indicate an individualized plan for the resident's scheduled toileting needs to promote continence.

Interviews with PSWs #105, #106, and RPN #109 indicated the resident was incontinent of bladder and bowel. The staff members indicated the resident had both cognitive and physical impairments and would not always call for toileting assistance. Staff should ask and take the resident to the washroom in order to promote the resident's continence. The staff members indicated the plan of care did not have an individualized schedule for meeting the resident's toileting needs.

Interview with the Acting Supervisor of Care #111 and the DOC confirmed that resident #001 had the assessed needs required for a scheduled toileting plan to promote his/her continence. The resident's plan of care did not have the toileting plan until it was brought to staff's attention after an interview with the inspector. [s. 51. (2) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training related to continence care and bowel management had been provided to all staff who provide direct care to residents on an annual basis.

Interview with PSW #106 revealed he/she had no recollection of receiving a continence care and bowel management training from the home in 2015.

Review of the education record indicated and interview with the Administrator confirmed that four per cent of all staff who provide direct care to residents had not been provided training in continence care and bowel management in 2015. [s. 221. (1) 3.]

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 sous la Loi de 2007 sur les foyers de soins de longue durée

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Issued on this 1st day of February, 2017

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

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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2016_168202_0022
Log No. / Registre no:	033034-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 30, 2017
Licensee / Titulaire de permis :	The Regional Municipality of York 17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1
LTC Home / Foyer de SLD :	YORK REGION NEWMARKET HEALTH CENTRE 194 EAGLE STREET, NEWMARKET, ON, L3Y-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Salonen Mackay

To The Regional Municipality of York, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

Upon receipt of this order the licensee shall:

1. Develop and implement a quality improvement process to audit, monitor and analyze the level of compliance by registered staff in the assessment, treatment and care for residents identified altered skin integrity including pressure wounds.

2. Ensure a written record is maintained to identify incidents when registered staff fail to assess, treat and provide care to residents identified with pressure wounds and/or altered skin integrity and actions that were taken to respond to these identified incidents.

3. Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents.

4. The policy review and training shall include all definitions of abuse, and must include the definition of neglect, as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

5. The licensee shall develop and submit a plan that includes tasks 1-4 and the person responsible for completing the tasks. The plan is to be submitted to valerie.johnston@ontario.ca by February 17, 2017, and implemented by May 31, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the residents are protected from abuse by anyone and free from neglect by the licensee or staff.

The home submitted an identified Critical Incident System (CIS) report in 2016, indicating that resident #016 had received improper/incompetent treatment that resulted in harm to the resident.

Resident #016 had been admitted to the home on an identified date in 2014. Resident #016's clinical records revealed that the resident had ongoing altered skin integrity since his/her admission. The resident required two staff total assistance for care, repositioning, and was incontinent.

A review of resident #016's progress notes from the time of his/her admission identified the resident to have periods of altered skin integrity to identified areas of the body that would heal and reopen. The notes specifically related to the CIS report for an identified date revealed the following:

-RN #102 had assessed resident #016's altered skin integrity and documented that the resident's altered skin integrity had improved over the past seven days and that the dressings have remained intact.

-RN #112 had assessed resident #016's altered skin integrity later the same day and documented that the resident's altered skin integrity had deteriorated and deemed unstageable. Only one dressing was found at the site of altered skin integrity and the area was heavily soiled.

Interviews with RN #112 and PSW #114 indicated that they had provided care to resident #016 at an approximate identified time, on the identified date of assessment as indicated above, when he/she had been found in need of personal care. PSW #114 stated that the resident did not have any dressings in place and the skin condition of identified areas of the resident's body was in poor condition. Both staff indicated that they were shocked and surprised that the resident's skin had deteriorated as they had read and heard in shift report that the resident's skin had improved. PSW #114 indicated that the DOC was notified at the time of incident.

An interview with the DOC indicated that he/she assessed resident #016's skin upon receipt of the report from PSW #114. The DOC indicated that the resident's skin was found to be compromised and not indicative of the documentation previously reported. The DOC confirmed that immediate treatment was provided and the resident's deteriorated skin integrity was reported to the home's skin and wound care lead, Supervisor of Care (SOC)

#104, for investigation.

An interview with SOC #104 indicated that during the home's investigation and review of resident #016's progress notes revealed that the resident's altered skin integrity should not have deteriorated so quickly. The SOC further indicated that he/she did not believe RN #102 assessed resident #016's identified area of altered skin integrity properly and during the home's investigation the RN confirmed that he/she did not assess resident #016's identified altered skin integrity area on the identified date, and documented that he/she had. The SOC confirmed that when RN #102 failed to assess the resident's identified altered skin integrity and falsified documentation in the progress notes, had subjected resident #016 to neglect. As a result of both the RN's actions and inactions, the resident did not receive appropriate assessment, treatment and care for his/her identified pressure wounds and as a result the resident's altered skin areas had deteriorated. The RN was disciplined.

An interview with RN #102 confirmed that on the above mentioned identified date, he/she did not assess resident #016's identified areas of skin integrity as scheduled. RN #102 further confirmed that he/she did not look resident #016's altered skin integrity and falsely documented an assessment of the resident's skin on what he/she had remembered the identified skin integrity area to have looked like several days earlier. The RN stated that as a result of his/her inactions, the resident did not receive the appropriate treatment or care that would have been required for the resident's skin and as a result the resident's already altered skin integrity had deteriorated substantially.

Interviews with the SOC, RN #102 and the Occupational Therapist (OT) confirmed that on the following day of the identified date where resident #016's skin integrity had been found in a deteriorated state, resident #016's inflatable ROHO wheelchair cushion was found to be damaged and visibly over inflated on the one side. When asked as to the length of time the inflatable ROHO cushion had been in disrepair, the SOC indicated that there was no way of knowing how long the resident had been sitting in a compromised position while in his/her wheelchair. The SOC further indicated that resident #016's inflatable ROHO cushion had been found on his/her wheelchair underneath a cover which would have prevented staff from seeing the cushion and its actual condition. Both RN #102 and SOC #104 confirmed that the state of the resident's inflatable ROHO cushion would have contributed to the deterioration of resident #016's skin.

Interviews with the DOC, SOC #104 and RN #102, indicated that residents who require the use of an inflatable ROHO cushion while in their wheelchair are to be monitored by front line staff for the appropriate inflation at the time of each use. When asked if there was any way to confirm that staff were monitoring the inflation and state of an inflatable ROHO cushion, the DOC, SOC #104 and RN #102 stated that there was not, however, were confident the front line staff had monitored resident #016's inflatable ROHO cushion.

An interview with PSW #114 indicated that inflatable ROHO cushions are not always checked by front line staff for inflation prior to use. PSW #114 indicated that at the start of his/her shift he/she would often find residents sitting on under inflated or overinflated ROHO cushion and would have to go to each resident to fit them properly in their ROHO. PSW #114 indicated that he/she became frustrated with being the only staff member monitoring the inflatable ROHO cushions and stated that as of January 2016, he/she stopped checking. PSW #114 indicated that on the date for which resident #016 altered skin integrity had been found in a deteriorated state confirmed that the resident's inflatable ROHO cushion did appear to be low in air.

Interviews with RN #102, PSWs #103, and #114 indicated that they had only received formal training on November 03, 2016, of the proper fit of an inflatable ROHO cushion. Staff indicated that prior to this date; they would have been shown by the vendor on an as needed basis. SOC #104 confirmed in an interview that staff had received training November 03, 2016, on adjusting inflatable ROHO cushions and that there had been no formal training prior to this date.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #016 had been identified with ongoing altered skin integrity since his/her admission in 2014. On an identified date, RN #102 failed to assess resident #016's identified altered skin integrity, falsified documentation in the progress notes and as a result of both the RN's actions and inactions, the resident did not receive appropriate assessment, treatment and care for his/her identified altered skin integrity and as a result the resident's altered skin areas had deteriorated.

Additionally, on the day after finding resident #016's skin had deteriorated the

resident's inflatable ROHO cushion used to prevent skin breakdown had been found damaged. The length of time that the resident had been placed on a compromised cushion is unknown and as staff indicated, may have been for some time. Staff indicated that the resident's inflatable ROHO cushion had not been monitored for appropriate inflation upon each use and formal training had not been provided to staff until November 03, 2016.

The scope of the non-compliance is isolated to resident #016. There is no previous non-compliance in this area of the legislation. [s. 19. (1)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Upon receipt of this order the licensee shall:

1. Within one week of receipt of the order, conduct a meeting between management and direct care staff from all shifts on the identified home area. The meeting shall allow direct care staff opportunities to collaborate in the assessment, development and implementation of resident #016's plan of care. The plan of care shall include the different aspects of care, including the resident's skin integrity, safety risks and the prevention of skin breakdown, bed/chair mobility, and the monitoring of the resident's inflatable ROHO cushion.

2. Continue to conduct meetings between management and direct care staff on the identified home area home area monthly, or at any other time resident #016's care needs change or the care set out in the plan is no longer necessary. Retain meeting minutes and attendance for one year.

3. Develop and implement a quality improvement process to ensure that all resident care plans are reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

4. The licensee shall develop and submit a plan that includes tasks 1-3 and the person responsible for completing the tasks. The plan is to be submitted to valerie.johnston@ontario.ca by February 17, 2017, and implemented by April 30, 2017.

Grounds / Motifs :

1. The licensee had failed to ensure that the resident be reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs have changed or care set out in the plan is no longer necessary.

The home submitted an identified Critical Incident System (CIS) report in 2016, indicating that resident #016 had received improper/incompetent treatment that resulted in harm to the resident.

Resident #016 had been admitted to the home on an identified date in 2014. Resident #016's clinical records revealed that the resident had ongoing altered skin integrity concerns since his/her admission and most notably to an identified area of the body. The resident required two staff total assistance for care,

repositioning, and was incontinent.

A review of resident #016's progress notes indicated that on an identified date the ongoing altered skin integrity concerns had deteriorated.

Interviews with RN #102, PSWs #101, #103, and #114 confirmed that resident #016's skin had been found in a deteriorated condition on the above identified date and as an intervention to promote healing both the plan of care and the written plan of care had been updated to direct all staff to keep the resident in bed and up in his/her wheelchair for meals only. Both the day shift RN and PSW #103 indicated that the resident's identified altered skin integrity had healed and the resident no longer required to be placed in bed after lunch. The evening shift staff PSW #101 and #114, both indicated that the resident should be placed in bed after lunch as the resident's identified areas of altered skin integrity remained fragile. The current written plan of care directs staff to place the resident in bed after all meals.

On an identified date during the course of the inspection, the inspector had observed the resident to be sitting in his/her wheelchair outside his/her room door for an identified period of time. RPN #100, PSWs #101 and #114 confirmed that the resident had been sitting in this same position from the beginning of their shift. The staff indicated that the resident should have been put back to bed after lunch, as the resident's skin continues to be fragile and compromised. PSW #114 and #101 stated that the resident had not been put to bed after lunch for at least four to six weeks and that he/she continually finds the resident sitting in his/her wheelchair at the beginning of their shift.

At a time during the identified observation period above, both PSWs #114 and #101 provided care to resident #016 in his/her room and indicated that the resident visibly needed care and his/her identified fragile skin had deteriorated. PSWs #114 and #101 indicated that the resident should have been put to bed after lunch by the day shift staff.

The DOC was made aware of the resident's skin condition and that the resident may not have received care for an identified period of time during the observation period. The DOC investigated and confirmed the condition of the resident's skin as described above and had confirmed through the home's video surveillance that the resident had received care during the period of time by the day shift staff and had been placed back in his/her wheelchair at that time.

The DOC indicated that the care needs specific to the resident #016's skin integrity required reassessment. The DOC confirmed that the resident #016's care needs had not been reassessed and the resident's plan of care had not been updated to reflect his/her current condition. The DOC further indicated that a meeting had been planned with all staff working on the resident's home area to review and revise his/her plan of care.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

On an identified date, an area of resident #016's skin had been assessed by staff to have deteriorated substantially. As skin care intervention both the plan of care and the written plan of care had been updated to direct all staff to keep the resident in bed and up in his/her wheelchair for meals only. Current clinical records indicated that the resident's skin remained altered. Interviews with direct care staff from both the day shift and evening shift yielded conflicting skin integrity interventions for the resident. The actual care that resident #016 required had not been assessed and interventions provided by direct care staff had not been consistent which resulted in further skin deterioration. The DOC confirmed that the current care needs of resident #016 had not been reassessed or care plan reviewed and revised to reflect his/her current needs.

The scope of the non-compliance is isolated to resident #016. There is no previous non-compliance in this area of the legislation. [s. 6. (10) (b)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

Upon receipt of this order the licensee shall:

1. Develop and implement a quality improvement process to ensure that all inflatable ROHO cushions used in the home, are well maintained, inflated appropriately and that all staff caring for residents who use an inflatable ROHO receive training on its use.

2.The quality improvement process shall also include a system to audit, monitor and analyze the level of compliance of all direct care staff in ensuring that inflatable ROHO cushions are well maintained and inflated appropriately.

3.The licensee shall develop and submit a plan that includes tasks 1-2 and the person responsible for completing the tasks. The plan is to be submitted to valerie.johnston@ontario.ca by February 17, 2017, and implemented by April 30, 2017.

Grounds / Motifs :

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

The home submitted an identified CIS report in 2016, indicating that resident #016 had received improper/incompetent treatment that resulted in harm to the resident. The CIS further indicated that resident #016's inflatable ROHO cushion

had been found damaged and had been identified as a contributing factor in the resident's skin deterioration.

Resident #016 had been admitted to the home at a time in 2014. Resident #016's clinical records revealed that the resident had ongoing altered skin integrity since his/her admission specifically to an identified area. The resident had been assessed to use a wheelchair with inflatable ROHO cushion, two staff total assistance for care, repositioning, and was incontinent.

A review of resident #016's progress notes from the time of his/her admission identified the resident to have periods of altered skin integrity that would heal and reopen. The notes indicated that on an identified date the resident's skin had been found to have deteriorated.

Interviews with the SOC, RN #102 and the Occupational Therapist (OT) confirmed that on the day after finding that resident #016's skin had deteriorated, resident #016's inflatable ROHO cushion was found to be damaged and visibly over inflated on the one side. When asked as to the length of time the inflatable ROHO cushion had been in disrepair, the SOC indicated that there was no way of knowing how long the resident had been sitting in a compromised position. The SOC further indicated that resident #016's inflatable ROHO cushion had been found on his/her wheelchair underneath a cover which had prevented staff from visualizing the cushions actual state. Both RN #102 and SOC #104 confirmed that the state of the resident's inflatable ROHO cushion had contributed to the deterioration of resident #016's identified altered skin integrity.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

Resident #016 had been identified with ongoing altered skin integrity since admission in 2014. On an identified date after the resident's skin had been found deteriorated the resident's inflatable ROHO cushion used to prevent skin breakdown had been found underneath a cover damaged. The length of time that the resident had been placed on a compromised cushion is unknown and as staff indicated that they had not visualized the ROHO cushion for some time. Staff indicated that the resident's inflatable ROHO cushion had not been monitored for appropriate inflation upon each use and formal training had not been provided to staff until November 03, 2016.

The scope of the non-compliance is isolated to resident #016. There is no previous non-compliance in this area of the legislation. [s. 15. (2) (c)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

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
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 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
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 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 30th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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