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 #/ Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2016;	2016_391603_0024 (A1)	019902-16, 022245-16, 022251-16, 022255-16, 022257-16, 022259-16, 022260-16, 022262-16	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

LINDSAY DYRDA (575) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date for all orders extended to December 31, 2016.

Issued on this 25 day of November 2016 (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

LINDSAY DYRDA (575) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 11-14, 17-21, 2016.

This Follow up inspection was related to Compliance Order (CO) #002 issued from inspection #2016_246196_0005, CO #001, 002, 003, 004, 005, 006 issued from inspection #2016_333577_0010, and CO #001 issued from inspection #2016_333577_0011.

A Complaint Inspection #2016_391603_0023 and a Critical Incident Inspection #2016_391603_0022 were conducted concurrently. Non-compliance regarding s. 6 (7) and r. 49 (2) were found in the Critical Incident Inspection #2016_391603_0022 report and the findings were issued in this report.

During the course of the inspection, the inspector(s) directly observed the delivery of resident care, staff to resident interactions, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, and reviewed staff education attendance records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Client Care Coordinator, Clinical Managers, Resident Assessment Instrument (RAI) Coordinators, Maintenance Supervisor, Environmental Services Supervisors, Staffing Coordinator,

Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Staff, residents, and family members.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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

- **6 WN(s)**
- **0 VPC(s)**
- **6 CO(s)**
- **4 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (7)	CO #006	2016_333577_0010	603
O.Reg 79/10 s. 44.	CO #004	2016_333577_0010	603

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. 6. Plan of care
Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #603 was following up on outstanding Compliance Order #001 issued during Inspection #2016_333577_0010 with a compliance date of September 30,

2016. As part of the order, the home was ordered to:
a) conduct routinely scheduled audits of residents' plans of care to ensure they were providing care as specified in each resident's plan of care. Each audit was to be reviewed by a member of the home's leadership team to verify accuracy of the audit;
b) the home was to provide retraining to all direct care staff of the home on residents' plan of care and revisions to the plan of care, especially related to nursing care measures;
c) the home was also to retrain all direct care staff related to the home's policies, procedures, and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff.

a) During the inspection, Inspector #603 interviewed the Acting Director of Care (ADOC) who explained that Resident Assessment Instrument (RAI) Coordinators conducted routinely scheduled audits of residents' plans of care to ensure staff were providing care as specified in each resident's plan of care.

Inspector #603 interviewed Clinical Manager #110 and #111 who explained that RAI Coordinators conducted routinely scheduled audits of residents' plans of care, the deficiencies found were addressed with the attending registered staff and once these were completed, these audits were returned to the Clinical Managers. At the time of the inspection, Clinical Manager #110 and #111 explained that they still had not put into practice, verifying accuracy of the audits.

b) The Inspector interviewed the ADOC and the Client Care Coordinator who explained that the home had not completed the required retraining to all direct care staff of the home on residents' plan of care and revisions to the plan of care, especially related to nursing care measures by the compliance date of September 30, 2016.

The Client Care Coordinator provided documents of the required retraining which revealed that 88 per cent (61 out of 69) RPNs, 83 per cent (24 out of 29) RNs, and 17 per cent (2 out of 12) recreation staff had not completed the retraining.

c) The ADOC and the Client Care Coordinator also explained that the home had not fully retrained all direct care staff related to the home's policies, procedures, and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff. The Inspector reviewed the home's "Mandatory Staffing Guidelines" document which revealed

that only 82 per cent of all direct care staff were retrained. [s. 6. (7)]

2. Inspector #616 reviewed a Critical Incident (CI) report submitted to the Director. The CI related to resident to resident abuse. According to the CI, resident #013 inappropriately touched resident #014, without consent.

The Inspector reviewed resident #013's care plan which identified certain behaviours. The interventions included to protect other residents and to never leave resident alone with other confused residents.

The Inspector interviewed PSW #135, PSW #136, and Clinical Manager #137 who verified that staff were aware of resident #013's behaviours towards certain residents, and explained that staff should not have positioned resident #014 in close proximity to resident #013. [s. 6. (7)]

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the pain management program provided the following: monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Inspector #603 was following up on outstanding Compliance Order #002 issued during Inspection #2016_246196_0005 with a compliance date of August 31, 2016. As part of the order, the home was ordered to conduct an audit of residents that were identified as experiencing pain or having interventions in place to manage pain, and to ensure that an individualized care plan to promote effective pain management was in place or implemented for those residents assessed as experiencing pain or having interventions in place to manage pain.

On October 12, 2016, Inspector #603 interviewed the ADOC and the Client Care Coordinator who explained that the home had done random resident audits and identified residents who may have been experiencing pain and if they did, the resident's care plan was assessed for pain interventions. The ADOC and the Client Care Coordinator confirmed that the home did not conduct an audit of all residents who were experiencing pain or having interventions in place to manage pain, nor did they review these residents' care plans to ensure that their pain was managed. [s. 52. (1) 4.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a

member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once
every two hours. (This requirement does not apply when bed rails are being used if the
resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining
evaluated only by a physician, a registered nurse in the extended class attending the
resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Inspector #603 was following up on outstanding Compliance Order #005 issued during Inspection #2016_333577_0010 with a compliance date of September 30, 2016. As part of the order, the home was ordered to conduct an audit, to be completed by a registered professional with training and current knowledge of restraints and restraint application, for all restraints used in the home. The audit was to contain the following: resident names, type of restraints in use, the criteria for use of restraints, the initial assessments of the application of restraints, mitigate any risk and address immediate concerns, ensure required orders, consents, care plans, and required documentation related to the application and use of the restraints, and to refer any outstanding restraint concerns to an Occupational Therapist (OT) to be further assessed and addressed.

Inspector #603 interviewed the ADOC who explained that between July 13th (the date of the order issued) and September 30, 2016 (the compliance date), only two of the seven floors had completed their audit as per this compliance order.

The Inspector reviewed the "Restraint Audit Checklist" for the two floors that had been completed, which identified all components of the order except for the criteria for use of the restraints. [s. 110. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect was complied with.

Inspector #603 was following up on outstanding Compliance Order #002 issued during Inspection #2016_333677_0010 with a compliance date of September 30, 2016. The home was ordered to retrain all direct care staff on the home's revised policy titled "Zero Tolerance of Abuse and Neglect of Residents" and ensure that the policy was complied with.

Inspector #603 interviewed the ADOC and the Client Care Coordinator who explained that the home had not completed all the required retraining on the home's revised policy "Zero Tolerance of Abuse and Neglect of Residents" by the compliance date of September 30, 2016.

The Inspector reviewed the home's retraining document for the "Policy Review: Zero Tolerance of Abuse and Neglect of Residents" which identified that between July 13, 2016, (the date of the order served) and September 30, 2016, (the compliance date), 292 out of 331 staff or 72 per cent of the staff had not completed the required retraining. [s. 20. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan sets out clear directions to staff and others who provide direct care to the resident.

Inspector #603 was following up on outstanding Compliance Order #003 issued during Inspection #2016_333577_0010 with a compliance date of September 30, 2016. The home was ordered to: a) put in place a system to conduct routinely scheduled audits of 24-hour admission care plans to ensure they were providing clear direction in each resident's plan of care and subsequent plans of care; b) each audit was to be reviewed by a member of the home's leadership team to verify accuracy of the audit; c) the home was also ordered to retrain all direct care staff of the home on 24-hour admission care plans, especially related to nursing care measures.

a) Inspector #603 interviewed the ADOC who explained that the RAI Coordinators conducted routinely scheduled audits of resident health care records to identify if there was a 24-hour admission care plan, but did not ensure that these 24-hour admission care plans were providing clear direction.

The Inspector reviewed the "LTC Clinical Documentation Audit" form which identified a question: "Is a 24 hr care on the chart for reference?".

The Inspector interviewed RAI Coordinators #107 and #108 who explained that when conducting the audits on the 24 hour admission care plan, they were asked to identify whether a 24 hour admission care plan existed on the resident's health record. At no time, were they asked to ensure that the 24 hour admission care plan provided clear direction.

b) The Inspector interviewed Clinical Manager #110 and #111 who explained that RAI Coordinators conducted routinely scheduled audits of 24 hour admission care plans and once these were completed, these audits were returned to the Clinical Managers. At the time of the inspection, Clinical Manager #110 and #111 explained that they still had not put into practice, verifying accuracy of the audits.

c) The Inspector interviewed the ADOC and the Client Care Coordinator who explained that the home had not completed the required retraining to all direct care staff of the home on 24-hour admission care plans by the compliance date of September 30, 2016. The Client Care Coordinator provided documents of the required retraining which revealed that 88 per cent (61 out of 69) of RPNs, 83 per cent (24 out of 29) of RNs, 17 per cent (two out of 12) of recreation staff had not completed this retraining. [s. 24. (3) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

DR # 004 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident had been assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #603 was following up on outstanding Compliance Order #001 issued during Inspection #2016_333577_0011 with a compliance date of August 31, 2016. The home was ordered to ensure that resident #002 and all other residents who had fallen, received a post-fall assessment using a clinically appropriate assessment instrument. The home was also to put into place a system to conduct routinely scheduled audits to ensure that residents who had fallen, were receiving a post-fall assessment.

Inspector #603 reviewed a Critical Incident (CI) report submitted to the Director, on a specific date, which related to an injury/hospital transfer/significant change in status. According the CI report, resident #021 was found on the floor and the staff assumed it was a fall. Four days before the CI, resident #021 was found sitting on the floor next to their bed. Later that day, resident #021 was observed to be injured, and the resident was sent to the hospital for x-rays and later returned.

Inspector #603 reviewed resident #021's progress notes which revealed that 12 days before the CI, the resident had been found on the floor, in their room, and had some injuries, but the resident stated they were not hurt. Three days after this incident, the resident was again found on the floor, in their room, and again, five days later, the resident was found sitting on the floor by their bed and denied any new pain.

Inspector #603 reviewed the resident's health care record which did not identify

any post-fall assessment completed for the three falls before the CI, using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #603 interviewed RN #139 who explained that at any time when a resident falls, a post-fall assessment is to be completed. In this case, RN #139 could not find post fall assessments completed for the same falls.

Inspector #603 also interviewed the Acting DOC who explained that with any falls, the staff were expected to complete an electronic post-fall assessment on Point Click Care.

Inspector #616 interviewed RAI Coordinator #108 who verified that there was no electronic post-fall assessments completed for the three falls on the specific dates. [s. 49. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 006

Issued on this 25 day of November 2016 (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
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Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LINDSAY DYRDA (575) - (A1)

Inspection No. / No de l'inspection : 2016_391603_0024 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 019902-16, 022245-16, 022251-16, 022255-16, 022257-16, 022259-16, 022260-16, 022262-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Nov 25, 2016;(A1)

Licensee / Titulaire de permis : ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD : HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Myrna Holman

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 ST. JOSEPH'S CARE GROUP, 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_333577_0010, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:
a) review and revise resident #013's plan of care and once completed, communicate the information to all staff caring for resident #013.
b) continue to conduct routinely scheduled audits of residents' plans of care to ensure they are providing care as specified in each resident's plan of care.
c) complete the retraining to all direct care staff (RNs, RPNs, PSWs) on residents' plan of care and revisions to the plan of care, especially related to nursing measures.
d) complete the retraining to all direct care staff related to the home's policies, procedures, and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #616 reviewed a Critical Incident (CI) report submitted to the Director. The CI related to resident to resident abuse. According to the CI, resident #013 inappropriately touched resident #014, without consent.

The Inspector reviewed resident #013's care plan which identified certain behaviours. The interventions included to protect other residents and to never leave resident alone with other confused residents.

The Inspector interviewed PSW #135, PSW #136, and Clinical Manager #137 who verified that staff were aware of resident #013's behaviours towards certain residents, and explained that staff should not have positioned resident #014 in close proximity to resident #013. (603)

2. Inspector #603 was following up on outstanding Compliance Order #001 issued during Inspection #2016_333577_0010 with a compliance date of September 30, 2016. As part of the order, the home was ordered to:
a) conduct routinely scheduled audits of residents' plans of care to ensure they were providing care as specified in each resident's plan of care. Each audit was to be reviewed by a member of the home's leadership team to verify accuracy of the audit;
b) the home was to provide retraining to all direct care staff of the home on residents' plan of care and revisions to the plan of care, especially related to nursing care measures;
c) the home was also to retrain all direct care staff related to the home's policies, procedures, and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff.

a) During the inspection, Inspector #603 interviewed the Acting Director of Care (ADOC) who explained that Resident Assessment Instrument (RAI) Coordinators conducted routinely scheduled audits of residents' plans of care to ensure staff were providing care as specified in each resident's plan of care.

Inspector #603 interviewed Clinical Manager #110 and #111 who explained that RAI

Coordinators conducted routinely scheduled audits of residents' plans of care, the deficiencies found were addressed with the attending registered staff and once these were completed, these audits were returned to the Clinical Managers. At the time of the inspection, Clinical Manager #110 and #111 explained that they still had not put into practice, verifying accuracy of the audits.

b) The Inspector interviewed the ADOC and the Client Care Coordinator who explained that the home had not completed the required retraining to all direct care staff of the home on residents' plan of care and revisions to the plan of care, especially related to nursing care measures by the compliance date of September 30, 2016.

The Client Care Coordinator provided documents of the required retraining which revealed that 88 per cent (61 out of 69) RPNs, 83 per cent (24 out of 29) RNs, and 17 per cent (2 out of 12) recreation staff had not completed the retraining.

c) The ADOC and the Client Care Coordinator also explained that the home had not fully retrained all direct care staff related to the home's policies, procedures, and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff. The Inspector reviewed the home's "Mandatory Staffing Guidelines" document which revealed that only 82 per cent of all direct care staff were retrained.

LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously as a WN and CO during Inspection #2016_333577_0010, a WN during Inspection #2016_333577_0011, a WN and VPC during Inspection #2016_246196_0006, a WN and VPC during Inspection 2016_246196_0005, a WN and CO during Inspection #2016_264609_0006, a WN during Inspection #2015_333577_0012, and a WN and VPC during Inspection #2014_246196_0016.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated actual harm and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation.
(603)

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

Dec 31, 2016(A1)

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2016_246196_0005, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures.
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Order / Ordre :

The licensee shall conduct an audit of all residents identified as experiencing pain or having interventions in place to manage pain, and to ensure that an individualized care plan to promote effective pain management is implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that the pain management program provided the following: Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Inspector #603 was following up on outstanding Compliance Order #002 issued during Inspection #2016_246196_0005 with a compliance date of August 31, 2016. As part of the order, the home was ordered to conduct an audit of residents that were identified as experiencing pain or having interventions in place to manage pain, and to ensure that an individualized care plan to promote effective pain management was in place or implemented for those residents assessed as experiencing pain or having interventions in place to manage pain.

On October 12, 2016, Inspector #603 interviewed the ADOC and the Client Care Coordinator who explained that the home had done random resident audits and identified residents who may have been experiencing pain and if they did, the resident's care plan was assessed for pain interventions. The ADOC and the Client Care Coordinator confirmed that the home did not conduct an audit of all residents who were experiencing pain or having interventions in place to manage pain, nor did they review these residents' care plans to ensure that their pain was managed.

LTCHA, 2007 S.O. 2007, r. 52. (1) 4 was issued previously as a WN and CO during Inspection #2016_246196_0005.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation.
(603)

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

Dec 31, 2016(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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_333577_0010, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall conduct a restraint audit, to be completed by a registered professional with training and current knowledge of restraints and restraint application for all restraints. The home must use the latest version of the "Restraint Audit Checklist, to track, monitor application of restraints" for the purpose of the audit, and the home must add the "criteria for the use of the restraints" into the checklist.

Once each resident audit is completed, the home must refer any outstanding restraint concerns to an Occupational Therapist (OT) to be further assessed and addressed. The home must indicate on the audit the requirements that were needed, and the reasons for referring to the OT.

Grounds / Motifs :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once
every two hours. (This requirement does not apply when bed rails are being used if the
resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Inspector #603 was following up on outstanding Compliance Order #005 issued during Inspection #2016_333577_0010 with a compliance date of September 30,

2016. As part of the order, the home was ordered to conduct an audit, to be completed by a registered professional with training and current knowledge of restraints and restraint application, for all restraints used in the home. The audit was to contain the following: resident names, type of restraints in use, the criteria for use of restraints, the initial assessments of the application of restraints, mitigate any risk and address immediate concerns, ensure required orders, consents, care plans, and required documentation related to the application and use of the restraints, and to refer any outstanding restraint concerns to an Occupational Therapist (OT) to be further assessed and addressed.

Inspector #603 interviewed the ADOC who explained that between July 13th (the date of the order issued) and September 30, 2016 (the compliance date), only two of the seven floors had completed their audit as per this compliance order.

The Inspector reviewed the "Restraint Audit Checklist" for the two floors that had been completed, which identified all components of the order except for the criteria for use of the restraints.

LTCHA, 2007 S.O. 2007, r. 110. (2) was issued previously as a WN and CO during Inspection #2016_333577_0010, a WN and CO during Inspection #2016_246196_0002, and a WN and VPC during Inspection #2015_333577_0012.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation.
(603)

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

Dec 31, 2016(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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2016_333577_0010, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall retrain all direct care staff on the home's revised policy titled "Zero tolerance of Abuse and Neglect of Residents".

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect was complied with.

Inspector #603 was following up on outstanding Compliance Order #002 issued during Inspection #2016_333677_0010 with a compliance date of September 30, 2016. The home was ordered to retrain all direct care staff on the home's revised policy titled "Zero Tolerance of Abuse and Neglect of Residents" and ensure that the policy was complied with.

Inspector #603 interviewed the ADOC and the Client Care Coordinator who explained that the home had not completed all the required retraining on the home's revised policy "Zero Tolerance of Abuse and Neglect of Residents" by the compliance date of September 30, 2016.

The Inspector reviewed the home's retraining document for the "Policy Review: Zero Tolerance of Abuse and Neglect of Residents" which identified that between July 13, 2016, (the date of the order served) and September 30, 2016, (the compliance date), 292 out of 331 staff or 72 per cent of the staff had not completed the required retraining.

LTCHA, 2007 S.O. 2007, s. 20. (1) was issued previously as a WN and VPC during Inspection #2016_435621_0012, a WN and CO during Inspection #2016_333577_0010, a WN and VPC during Inspection #2016_246196_0006, and a WN and CO during Inspection #2015_43521_0012.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation.
(603)

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Vous devez vous conformer à cet ordre d'ici le :

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Dec 31, 2016(A1)

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2016_333577_0010, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident.
O. Reg. 79/10, s. 24 (3).

Order / Ordre :

The licensee shall:
a) conduct routinely scheduled audits of 24-hour admission care plans to ensure they are providing clear direction in each resident's plan of care and subsequent plans of care, and once the audits are completed, members of the leadership team must review some of the audits for accuracy.
b) retrain all direct care staff (RNs, RPNs, and PSWs) on 24-hour admission care plans, especially related to nursing care measures.

Grounds / Motifs :

1. The licensee has failed to ensure that the 24-hour admission care plan sets out clear directions to staff and others who provide direct care to the resident.

Inspector #603 was following up on outstanding Compliance Order #003 issued during Inspection #2016_333577_0010 with a compliance date of September 30,

2016. The home was ordered to: a) put in place a system to conduct routinely scheduled audits of 24-hour admission care plans to ensure they were providing clear direction in each resident's plan of care and subsequent plans of care; b) each audit was to be reviewed by a member of the home's leadership team to verify accuracy of the audit; c) the home was also ordered to retrain all direct care staff of the home on 24-hour admission care plans, especially related to nursing care measures.

a) Inspector #603 interviewed the ADOC who explained that the RAI Coordinators conducted routinely scheduled audits of resident health care records to identify if there was a 24-hour admission care plan, but did not ensure that these 24-hour admission care plans were providing clear direction.

The Inspector reviewed the "LTC Clinical Documentation Audit" form which identified a question: "Is a 24 hr care on the chart for reference?".

The Inspector interviewed RAI Coordinators #107 and #108 who explained that when conducting the audits on the 24 hour admission care plan, they were asked to identify whether a 24 hour admission care plan existed on the resident's health record. At no time, were they asked to ensure that the 24 hour admission care plan provided clear direction.

b) The Inspector interviewed Clinical Manager #110 and #111 who explained that RAI Coordinators conducted routinely scheduled audits of 24 hour admission care plans and once these were completed, these audits were returned to the Clinical Managers. At the time of the inspection, Clinical Manager #110 and #111 explained that they still had not put into practice, verifying accuracy of the audits.

c) The Inspector interviewed the ADOC and the Client Care Coordinator who explained that the home had not completed the required retraining to all direct care staff of the home on 24-hour admission care plans by the compliance date of September 30, 2016. The Client Care Coordinator provided documents of the required retraining which revealed that 88 per cent (61 out of 69) of RPNs, 83 per cent (24 out of 29) of RNs, 17 per cent (two out of 12) of recreation staff had not completed this retraining.

LTCHA, 2007 S.O. 2007, r. 24. (3) (b) was issued previously as a WN and CO during Inspection #2016_333577_0010, and a WN and CO during Inspection

#2016_236196_0002.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation.
(603)

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

Dec 31, 2016(A1)

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant: 2016_333577_0011, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:
a) ensure that resident #021 and all residents who have fallen, receive a post fall assessment using a clinically appropriate assessment instrument.
b) continue to conduct routinely scheduled audits to ensure that residents who have fallen, are receiving a post fall assessment.
c) review with all front line staff the home's electronic post-fall assessment on Point Click Care and it's requirements for falls. The staff must sign off on the information received.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident has fallen, the resident had been assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #603 was following up on outstanding Compliance Order #001 issued during Inspection #2016_333577_0011 with a compliance date of August 31, 2016. The home was ordered to ensure that resident #002 and all other residents who had fallen, received a post-fall assessment using a clinically appropriate assessment instrument. The home was also to put into place a system to conduct routinely scheduled audits to ensure that residents who had fallen, were receiving a post-fall assessment.

Inspector #603 reviewed a Critical Incident (CI) report submitted to the Director, on a specific date, which related to an injury/hospital transfer/significant change in status. According the CI report, resident #021 was found on the floor and the staff assumed it was a fall. Four days before the CI, resident #021 was found sitting on the floor next to their bed. Later that day, resident #021 was observed to be injured, and the resident was sent to the hospital for x-rays and later returned.

Inspector #603 reviewed resident #021's progress notes which revealed that 12 days before the CI, the resident had been found on the floor, in their room, and had some injuries, but the resident stated they were not hurt. Three days after this incident, the resident was again found on the floor, in their room, and again, five days later, the resident was found sitting on the floor by their bed and denied any new pain.

Inspector #603 reviewed the resident's health care record which did not identify any post-fall assessment completed for the three falls before the CI, using a clinically

appropriate assessment instrument that was specifically designed for falls.

Inspector #603 interviewed RN #139 who explained that at any time when a resident falls, a post-fall assessment is to be completed. In this case, RN #139 could not find post fall assessments completed for the same falls.

Inspector #603 also interviewed the Acting DOC who explained that with any falls, the staff were expected to complete an electronic post-fall assessment on Point Click Care.

Inspector #616 interviewed RAI Coordinator #108 who verified that there was no electronic post-fall assessments completed for the three falls on the specific dates.

LTCHA, 2007 S.O. 2007, r. 49. (2) was issued previously as a WN, VPC during Inspection #2016_435621_0012, a WN and CO during Inspection #2016_333577_0011, and a WN and VPC during Inspection #2015_333577_0012.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated actual harm, and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation.
(603)

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

Dec 31, 2016(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 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

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 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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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
Toronto ON M5S 2B1
Télécopieur : 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 25 day of November 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDSAY DYRDA - (A1)

Service Area Office /
Bureau régional de services : Sudbury