Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
May 1, 2015	2015_195166_0007	O-001649-15	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

CAROLINE TOMPKINS (166), KELLY BURNS (554), SAMI JAROUR (570)

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): April 7- April 10, 2015 and April 13-April 16, 2015

Critical Incident Log O-001811-15 was also inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Residents, Family, Resident Council Representative, Resident Services Coordinator, Administrator, Director of Care, Assistant Director of Care, Corporate Consultants, RAI Coordinator, Environmental Manager, Program Manager, Activity Aides, Music Therapist, Personal Support Workers, Registered Practical Nurses, Registered Nurses, Dietary Aides.
Dietitian, Housekeepers and the Physiotherapist Assistant .
The inspectors toured the residents' home and common areas, observed staff to resident interaction during the provision of care, resident social activities, residents' dining experience, medication administration, infection control practices and reviewed the licensee's policies related to nutritional assessment and care, interprofessional clinical programs, which included dementia care, person-centred care and residents' council, infection prevention and control

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **7 WN(s)**
- **5 VPC(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to comply with LTCHA, 2007, s. 6 (2), by ensuring that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.
During an interview, Resident #23 indicated that the resident used to receive 2 baths a week and receiving a bath was the resident's preference. The resident indicated they no longer receive a bath but receives shower twice a week instead.
Resident #23 plan of care related to bathing indicates:
Resident #23 is to have a comfortable bathing experience. Interventions include, refer to bath listing and or point of care (POC, electronic documentation record) for bath/shower schedule.
A review of the clinical health record (Point of Care flow records, assessments, progress notes, care conference notes) specific to Resident #23 was reviewed for the period of October 01, 2014 through to April 14, 2015, the review failed to provide evidence that Resident #23/Substitute Decision Maker (SDM) was involved in an assessment as to bathing preference.

Resident #51
During an interview on April 14, 2015, Resident #51 indicated that the resident is not offered choice relating to bathing options. Resident indicated receiving two showers weekly but indicated that the preference would be to have a bath.
Resident #51's plan of care related to bathing :
Goals indicated are for resident to have a comfortable bathing experience. Interventions include, refer to bath list and POC for bath/shower schedule.
A review of the clinical health record (Point of Care flow records, assessments, progress notes, care conference notes) specific to Resident #51 was reviewed for the period of October 01, 2014 through to April 14, 2015, the review failed to provide evidence that Resident #51 /SDM was involved in an assessment as to bathing preference.

A review of the bathing/shower scheduled on all four resident home areas indicated that of the 124 residents residing within the home, only 5 residents are schedule to have a tub bath, the remainder have been assigned showers.

Personal Support Workers #100 and #124, working on a specified resident home area indicated that they were told that the majority of the residents prefer showers(the PSWs were not able to recall who had provided that information); staff indicated that they follow

the bath/shower schedule and do not offer resident's choice as to bathing options; if a bath is not specifically typed on the sheet then a shower is given to the resident. Staff #100 and #124 indicated that a resident's bathing preference would be indicated on the kardex in point of care (electronic health record),staff were unable to demonstrate where specifically in the kardex or in the plan of care where a resident's preference around bathing was indicated.

Interview with Personal Support Worker #109 indicated the PSW was told that all but one resident residing on a specified resident home area prefer to have showers(the PSW was not able to recall who provided that information.

Assistant Director of Care indicated that residents/SDM are offered choice of bathing and showers upon admission but indicated that this choice is not reviewed again with either resident or family. ADOC could not indicate where this choice would be documented.

The home's policy, Bathing and Showering (#LTC-H-40) directs that all Residents are to be provided with a personal and individualized bath or shower; the experience is to be comforting, relaxing, and stress free and one that respects personal choice, dignity and privacy of the resident.

Director of Care indicated that the expectation is that residents are offered a choice and or a preference specific to bathing and or showering prior to care being provided. The Director of Care indicated the DOC was not aware that choice around bathing was not being offered to residents. [s. 6. (2)]

2. Resident #17:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan.
Interview with family of Resident #17 indicated that they felt resident was not receiving adequate assistance during meal times.

The plan of care for Resident #17 indicated the following:

- Eating, requires support; interventions included are:
- requires assistance, if refusing to eat remind the resident the risk of skipping meals,
- monitor for low blood sugar,
-orientate resident to the type and location of food on the plate using the clock method,

-place cups within reach and describe location of food and utensils.

- Nutritional Risk is high risk
Interventions include:
-encourage small bites and observe swallowing before taking another bite, needs close one to one supervision,
-encouragement to eat and drink fluids, -
pureed soup and crustless bread, and estimated fluid intake 1700mL daily.

The following observations were made during the dates of April 14 and April 15, 2015:

April 14, 2015, at approximately 08:50 hours Resident #17 was observed sitting in a wheelchair at the dining room table with head down ; Personal Support Worker #109 was attempting to assist resident, but resident appeared to sleeping.
Resident was observed at approximately 09:05 hours with an untouched breakfast meal and fluids in front of the resident, the resident appeared to be asleep; Resident #17 continued to sit at the dining room table for approximately ten minutes without staff approaching to assist. At no time did staff indicate to resident where food or beverages were on the table.

- Lunch observation – April 14, 2015, at approximately 12:05 hours Resident #17 was observed sitting in a wheelchair at the dining room table, resident appeared to be sleeping; a plate (regular, not sectioned) containing a half of sandwich (with crust) and a bowl of salad was in front of resident; the meal sat in front of the resident until approximately 12:15 hours prior to a registered nursing staff who handed the resident a sandwich. Resident's plate was removed at 12:27 hours with no salad eaten by resident or offered.
At 12:32 hours, a PSW #108 placed a bowl of baked custard in front of the resident without saying anything to the resident; Resident #17 continued to sit at the table until 12:49 hours without staff offering any assistance nor did resident attempt to eat the dessert. It was further observed that there was three cups of beverages placed in front of the resident at the beginning of the lunch meal which were never offered to the resident or consumed.

April 15, 2015, at approximately 08:45 hours Resident #17 was observed sitting in a wheelchair at the dining room table, a plastic mug containing porridge was handed to resident by PSW #109; PSW encouraged resident to drink the porridge, then walked away to help elsewhere. Resident #17 was observed drinking a few mouthfuls of the

porridge then attempted to place the mug of porridge onto the table without success; resident continued to hold the mug, eventually resting it on the right arm of the wheelchair, resident then appeared to be sleeping. At approximately 09:07 hours PSW #108 removed the mug of porridge from resident's hand without offering assistance and a few minutes later the same staff returned and provided resident with a plate(non sectioned) containing eggs, toast (with crust) and jam; staff did not tell the resident a plate of food was in front of the resident nor did staff offer resident assistance.
At approximately 09:17 hours, PSW #109 approached resident, sat and began assisting resident with breakfast.

Personal Support Worker #109 indicated that Resident #17 physical status has declined and most days resident now requires staff to physically assist with meals.

Registered Dietitian indicated Resident #17 does require one to one assistance due to medical condition; RD indicated resident needs more physical assistance with meals when the resident is tired or is exhibiting responsive behaviours.

The plan of care was not provided to Resident #17 as planned, specifically:
- Resident was not provided one to one assistance during meals during observations notes above
- Resident was not told where on the plate, food and beverages were located using the clock method or any other verbal cueing
- Resident was not provided required assistive devices (sectioned/divided plate) during meals observed
- Resident was given bread and or toast containing crust

Director of Care indicated that the expectation is that care is to be provided as documented in the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care, specifically for Resident #17 related to meal assistance and bathing options for all residents are based on an assessment and the care is provided according to each residents' individual needs and preferences, to be implemented voluntarily.

WN #2: 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 has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.
The following observations were made during the dates of April 7, 2015, through to April 15, 2015.
-Resident homes area of Sandy Beach, Alderwood and Mitchell Park:
-spa rooms (tub/shower area) - at the shower stall threshold, the laminate flooring is lifting with subflooring exposed. The subfloor is wet and when stepped upon water seeps through the cracked and lifted laminate flooring.
The surface of the flooring is porous and poses a potential infection control issue as difficult to clean.
Alderwood
Shower Room - shower stall - the caulking is chipped and missing in areas.
- flooring chipped and or lifting, especially by the drain, there is a large area of missing and jagged flooring -creating a potential possible trip hazard and poses a potential infection control issue as difficult to clean.
- the lower edge the laminate covering the vanity is missing leaving jagged edges.
-wall damage by shower stall - holes and the steel corner bead is exposed.
-in resident room, 2116, by the bed, there is a large hole in the drywall approximately 6cm wide by 30 cm long (the hole is below the level of the mattress).
-Entrance to resident room 2219 at the mid level of the door frame,the veneer is cracked creating sharp edges. (a potential risk of injury). The dry wall on the lower wall at the foot of the resident's bed is scarred through the drywall (approximately 30cm in length. The surface is porous and poses a potential infection control issue as difficult to clean.
The window glass in resident room #2219 is cracked and at the time of observation the cracks in the glass are covered with duct tape. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, specifically the floors and the furnishings in the spa rooms and the walls and door frames and the window glass in residents' rooms are maintain in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 failed to comply with LTCHA, 2007, s. 20 (1), by ensuring that the licensee's written policy that promotes zero tolerance to abuse is complied with.

During an initial resident interview, Resident #23 indicated that a Personal Support Worker entered the resident's room, on a specified day, to provide resident with care; the resident indicated being told by the PSW that the resident required new clothing due to the resident's physical size. The Resident further indicated the staff continued to speak rudely, remarking that the resident had a body odour.

Resident #23 indicated being upset by the staff member's comments, stating it made the resident feel depressed and ashamed. Resident #23 could not recall if the interaction with PSW had been reported to anyone.

Log # O-001811-15, for Resident #40:
A critical incident (CI) report was submitted indicating Resident #40 reported that PSW #111 came into the resident's room and questioned the resident regarding a conversation that occurred between the charge nurse and resident pertaining to the care PSW #111 had provided to the resident on prior shifts. RPN #112 documented the incident in an email communication to the DOC and indicated that Resident #40 reported that due to the interaction between the PSW #111 and the resident, Resident #40 did not want PSW #111 as a caregiver anymore.
Review of RPN #112's documentation indicated that Resident #40 was very upset about the incident.

Interview with Staff #123 (Resident Support Services Coordinator) who documented

talking to Resident #40 about the incident with Staff #111 indicated that when the Coordinator spoke to Resident #40, the resident was upset about the interaction and comments made by PSW #111.

The home's policy, Resident Non-Abuse-Ontario (#LP-C-20-ON) directs that the organization is committed to providing a safe and supportive environment in which all Residents are treated with dignity and respect. All organizational staff members must protect the rights of each and every Resident entrusted to their care. The home's policy defines emotional abuse, the definition includes, insulting, humiliating gestures, actions or behaviours that are performed by anyone other than a resident.

The Director of Care indicated that the PSWs' comments were not reflective of the home's policy. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff comply with the licensee's written policy that promotes zero tolerance to any abuse, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to Log # O-001811-15, for Resident #40:
The licensee has failed to ensure that the Director was immediately notified when the home had reasonable grounds to suspect abuse of a resident by a staff member that resulted in harm or risk of harm to the resident.

On March 5, 2015 Critical Incident Report #2895-000005-15 was submitted to the Ministry of Health and Long-Term Care by the home to report an incident of staff to resident emotional abuse.

The Critical Incident (CI) report submitted described the incident as follows:
Resident # 40 reported that PSW #111 came into the resident's room and questioned the resident regarding a conversation that occurred with the charge nurse and resident pertaining to the care PSW #111 provided to the resident on prior shifts.
Review of clinical documentation indicated that Resident #40 was very upset about the incident.

Review of CI# 2895-000005-15 and the licensee's investigation into the incident indicated the alleged staff to resident emotional abuse was reported to the Ministry of Health and Long-Term Care 5 days post incident.

Inspector #570 was in correspondence with Central Intake Team (CIATT) administrative assistant and SAC (Still Action Centre) who indicated that there was no recorded email or phone call from the licensee regarding the February 27,2015 incident.

There is no evidence that the Director was immediately notified of the emotional abuse incident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately notified when the home had reasonable grounds to suspect abuse of a resident by a staff member that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by ensuring that all staff participate in the implementation of the program.

The following observation was made during the morning and shortly after lunch on April 07, through to April 09, 2015:

- two unlabeled urinals were observed hanging from the toileting grab rails in the washroom of a shared resident room , on the morning of April 08, 2015, one of the urinals contained pale brownish fluid.

Registered Nurse #107 and Personal Support Workers #108 and #109 all indicated that the personal care items, including urinals are to be labeled for individual resident use. Staff #108 indicated that the urinals were not to be stored in resident washrooms.Staff were unable to determine which urinal belonged to either of the two residents who resided in room #1201.

Director of Care, who is also the lead for Infection Control within the home, indicated that the expectation is that urinals (all resident care items) are to be individually labeled for resident use and are to be cleaned following use and placed inside the resident's bedside table.

Further observations:
On April 13 and on April 16/15 2015 - During observations of two medication passes

completed by two different Registered staff , it was observed that at no time did the Registered staff perform hand hygiene before or after resident contact.
- April 15, 2015 – at approximately 0830, a Dietary Staff #117 was observed touching and rubbing the arm of Resident #44 during a conversation,following the conversation dietary staff entered the servery and began preparing a cart of beverages; no hand hygiene was observed being performed by this staff after contact with Resident #44.

Director of Care indicated that all staff receives infection control education, which includes hand hygiene (4 Moments) annually. DOC indicated that the expectation is that staff perform hand hygiene before and after contact with any resident. [s. 229. (4)]

2. The licensee has failed to ensure that there a hand-hygiene program in accordance with
evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.
PIDAC directs the placement of Alcohol Based Hand hygiene Rub dispensers:
Installing alcohol-based-based hand rub dispensers at the point-of-care improves adherence to hand hygiene. Point-of-care is the place where three elements occur together: the client/patient/resident, the health care provider and care or treatment involving client/patient/resident contact. Hand hygiene products available at point-of-care are to be easily accessible to staff by being as close as possible, i.e., within arm's reach, to where client/patient/resident contact is taking place.
There are 74 private resident rooms in this home, access to point-of-care hand hygiene agents were found to be between residents' rooms in the hallway outside of the rooms. There was no access to point-of-care hand hygiene agents inside the resident rooms.
Interview with PSWs #118,119,120,121, and 122 indicated that they did not carry personal hand sanitizers with them during the provision of resident care.
Hand hygiene agents not accessible at point of care locations places residents at increased risk of cross infection. [s. 229. (9)]

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 there a hand-hygiene program in accordance with
evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.68(2)(e)(ii), whereby the licensee did not ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record each resident's height annually.

Review of clinical records for 37 residents related to weights and heights, indicated that 33 of the resident health care records reviewed were found to lack an annual recorded height measurement.
Review of the licensee's policy related to Nutritional Assessment and Care LTC-G-60 and interview with the Dietitian indicated each residents' height is to be measured and documented at a minimum annually. [s. 68. (2) (e) (ii)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of Residents' Council in developing and carrying out the satisfaction survey, and acting on its results.
Interview with Resident #23, who is a Resident Council representative indicated that the licensee has made the Council aware of the survey results but did not seek the advice of Council in developing and carrying out the survey.
Interview with Staff #114, who is the liaison between the Resident Council and the licensee, indicated the satisfaction survey completed in 2014 was developed by an outside agency and did not seek the advice of the Residents' Council in developing and carrying out the survey. [s. 85. (3)]

Issued on this 1st day of May, 2015

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

Original report signed by the inspector.