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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2018	2018_560632_0002	029679-17	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 700 MARKHAM ON L3R 9W2

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

Extendicare Hamilton
90 Chedmac Drive HAMILTON ON L9C 7S6

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

YULIYA FEDOTOVA (632), CATHIE ROBITAILLE (536), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 9, 10, 11, 12, 15, 2018.

The following inspections were completed concurrently with the Resident Quality Inspection.

Critical Incident System Report:
033611-16 - related to: Prevention of Abuse & Neglect, Responsive Behaviours
034473-16 - related to: Prevention of Abuse & Neglect
023521-17 - related to: Falls Prevention

Complaints:
030136-16 - related to Prevention of Abuse & Neglect, Personal Support Services

Inquiries:
021291-17 - related to: Falls Prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Co-ordinator, the Back up RAI Co-ordinator, Resident Program Manager (RPM), Dietary Manager, the Registered Dietitian (RD), Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), with residents and their families.

During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control policy, reviewed inspection related documentation, relevant clinical records, relevant policies, procedures, and practices within the home, reviewed meeting minutes, investigation notes, staff files, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was 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 changed.

Review of resident #003's Minimum Data Set (MDS) assessment completed on an identified date in July, 2017, identified that the resident had alterations in bladder function. Review of the MDS assessment completed on an identified date in October, 2017, and in December, 2017, identified that resident #003 had a decline in bladder function. Review of resident #003's care plan, which was last revised on an identified date in September, 2017, revealed the it had not been updated related to the identified decline.

Interview with the RAI Co-ordinator and the backup RAI Co-ordinator on an identified date in January, 2018, identified that resident #003 had a decline in bladder function and confirmed that their care plan was not revised.

2. A review of MDS assessment (locked on an identified date in November, 2016) indicated that resident #010 required extensive assistance from two staff for an identified Activity of Daily Living (ADL). Review of plan of care (last updated on an identified date in November, 2016) indicated that the resident required extensive assistance by one staff for the same ADL. A review of the most recent MDS assessment (locked on an identified date in November, 2017) indicated that resident #010 required extensive assistance by two staff for three ADLs including the ADL previously identified. Review of the most recent plan of care (last updated on an identified date in December, 2017), indicated that resident #010 required extensive assistance from one staff for three identified ADLs. On an identified date in January, 2018, staff #117 was interviewed and indicated that the resident required extensive assistance by two staff for three ADLs. On an identified date in January, 2018, staff #110 indicated that direct care staff referred to the resident's plan of care, related to their ADL, to Kardex section in their portable tablets, when using Point of Care (POC). On an identified date in January, 2018, RAI Co-oridinator and Back up RAI Co-ordinator staff members confirmed that the plan of care for resident #010 was not reviewed and revised at least every six months and at any other time when the resident's care needs changed, which was acknowledged by the DOC.

Please note: this non-compliance was issued as a result of CI log # 034473-16, which was conducted concurrently with the RQI.

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 and ensuring that the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 failed to ensure that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's policy #RC-15-01-01 "Falls Prevention and Management Program," last updated February 2017, directed registered nursing staff to:
i) Hold a Post-Fall Huddle, ideally within the hour and complete a post-fall assessment as soon as possible.
ii) Initiate [an] incident report".

Review of the home's critical incident report and staff interviews identified that on an identified date in September, 2017, resident #011 had a fall resulting in identified injury. The resident was transferred to hospital.

Review of the clinical records for resident #011 identified that they were at risk for falls. An incident note was completed by staff #118 for the fall on an identified date in September, 2017, and they completed a progress note for a second fall later that day. Review of the assessments tab in Point Click Care (PCC) did not identify any identified assessments for the falls on an identified date in September, 2017, and identified an assessment that was initiated after the resident's fall on an identified date in September, 2017, but was struck out as incomplete.

Interview with the DOC on an identified date in January, 2018, acknowledged that at the time of resident #011's falls on an identified date in September, 2017, staff #118 was a new employee. The DOC confirmed that identified assessments were not completed for the falls on an identified date in September, 2017, but identified that an identified device was initiated, as per the progress notes, prior to the fall on an identified date in September, 2017. The DOC identified they were unsure why the identified assessment from an identified date in September, 2017, was crossed out as incomplete, but acknowledged that some areas of the assessment had not been completed.

The home did not ensure that an identified assessment using a clinically appropriate assessment instrument was completed for resident #011's falls on an identified date in September, 2017, and that the post-fall assessment initiated by staff #120 was not completed in full for resident #011's fall on an identified date in September, 2017.

Please note: this non-compliance was issued as a result of CI log #023521-17, which was conducted concurrently with the RQI.

2. The home's policy #RC-15-01-01 "Falls Prevention and Management Program," last updated February 2017, directed registered nursing staff to:
i) Hold a Post-Fall Huddle, ideally within the hour and complete a post-fall assessment as soon as possible.
ii) Initiate [an] incident report.

Review of the clinical record for resident #020 identified that they had a fall on an identified date in January, 2018. Review of the assessments tab in PCC did not identify an identified assessment for the fall. On an identified date in January, 2018, the DOC reviewed, upon request, resident #020's clinical record and confirmed that an identified assessment was not completed for their fall on an identified date in January, 2018, as per the home's policy.

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 and ensuring that where the condition or circumstances of the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The home's policy #RC-14-01-01 "Continence Management Program," last updated in February 2017, directed registered nursing staff to:
i. Complete a Continence Assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence. An assessment was to be completed:
- Upon admission for all residents;

- With any deterioration in continence level;
- At required jurisdictional frequency, and
- With any change in condition that may affect bladder and bowel continence.

Review of resident #003's MDS assessment completed on an identified date in July, 2017, identified that the resident had alterations in bladder function. Review of the MDS assessment completed on an identified date in October, 2017, identified that the resident had other alterations in bladder function. Review of the clinical record identified the identified assessment was last completed on an identified date in February, 2015. There were no further identified assessments found in the clinical record.

Interview with the DOC on an identified date in January, 2018, confirmed that an identified assessment should have been completed when resident #003's identified status had changed, as per the home's policy.

The home did not ensure that an assessment using a clinically appropriate instrument was completed for resident #003 after they experienced a change in their identified status.

2. The home's policy #RC-14-01-01 "Continence Management Program," last updated February 2017, directed registered nursing staff to:
i. Complete a Continence Assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence. An assessment was to be completed:
- Upon admission for all residents;
- With any deterioration in continence level;
- At required jurisdictional frequency, and
- With any change in condition that may affect bladder and bowel continence.

Review of resident #004's MDS assessment completed on an identified date in February, 2017, identified that the resident had alterations in bladder function. Review of the MDS assessment completed on an identified date in May, 2017, identified that the resident had other alterations in bladder function. Review of the clinical record, dating back until admission on an identified date, did not identify any identified assessments for resident #004.

Interview with the DOC on an identified date in January, 2018, initially acknowledged that they would not have expected an identified assessment to be completed when resident

#004's identified status had changed, however, after review of the home's policy, identified that an identifed assessment should have been completed.

The home did not ensure that an assessment using a clinically appropriate instrument was completed for resident #004 after they experienced a change in their identified status.

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 and ensuring that 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs complied with the manufacturer's instructions for expiration dates and pharmacy directives.

On identified date in January, 2018, all medication carts in the home were checked for specific medications and treatments to ensure they were dated as to when they were opened, and when they were to be discarded 28 days later as per the home's pharmacy directive unless otherwise directed.

The home's pharmacy policy titled "Expiry and Dating of Medications", policy number: 5-1, dated: February, 2017, stated that designated medications must be dated when opened and removed from stock when expired. The home's pharmacy policy titled "Recommended Expiry Dates Once Product is Open", policy number: 5-2, dated: April, 2017, stated that an identified medication kept at room temperature: 28 days (label with date when removed from fridge). All other specific medications (not identified on chart) 28 days unless otherwise stated by manufacturer.

The inspector observed the following in the medication carts:

i) Resident #013 - an identified medication was not dated as to when it had been opened, resident #012 - an identified medication was not dated, when it had been opened, resident #012- identified medications were not dated, when had been opened. The manufacturers' instructions for identified medications stated: once the bottle had been opened, can be kept at room temperature for up to 28 days.

ii) Resident #014 - an identified medication was opened on an identified date in November, 2017 and should have been disposed of on an identified date in December, 2017, resident #015 - an identified medication was not dated, when opened. Dispensing date for the identified medication had exceeded 28 days at the time of inspection.

iii) Resident #016 - an identified medication was dated as being dispensed on an identified date in November, 2017 however, not dated when it was opened.

Registered staff #106, #107 and #108 confirmed that opened identified medication was kept in the medication cart and that the identified medications found in each of their medication carts was not discarded as per the home's pharmacy policy or manufacturer's instructions.

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 and ensuring that drugs complied with the manufacturer's instructions for expiration dates and pharmacy directives, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in accordance to O. Reg. 79/10, s. 221(2)(1), at times or at intervals provided for in the regulations: any other areas provided for in the regulations, the area of falls prevention and management in accordance with O. Reg. 79/10, s. 221(1)1, in relation to the following:

The DOC confirmed that 118 staff in the home provided direct care to residents and that of those, 34 were registered staff. Training documents provided by the home at the time of this inspection indicated that 88 of 118 or 75 per cent (%) of direct care staff had received retraining in the area of the "Falling Leaf Falls Prevention Program" in 2017, and 26 out of 34 or 76% of registered staff had received retraining in the area of "Falls Prevention Assessments and Resources" in 2017. On an identified date in January, 2018, the DOC confirmed that 100% of staff had not received retraining in the area of falls prevention and management in 2017.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On an identified date in January, 2018, the Administrator confirmed that the RD had not taken part in the annual evaluation of the medication management system in the home and to recommend any changes necessary to improve the system.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents were reviewed and analyzed, corrective action was taken as necessary and a written record was kept of everything required under clauses (a) and (b).

During interview with the DOC they stated that medication incidents were reviewed and analyzed at the Registered Staff meetings, however, they confirmed that they had not maintained a record in the meeting minutes.

The home failed to ensure that there was a written record kept, when medication incidents and adverse drug reactions were reviewed and analyzed.

2. The home failed to ensure that there was a written record kept of any changes and improvements identified in the quarterly review.

During interview with the DOC they confirmed that a quarterly review of all medication incidents in the home, including any changes or improvements since the last time of the last review in order to reduce and prevent medication incidents, had not been completed.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 223. Orientation for volunteers

Specifically failed to comply with the following:

s. 223. (1) Every licensee of a long-term care home shall ensure that every volunteer receives the orientation provided for in section 77 of the Act. O. Reg. 79/10, s. 223 (1).

s. 223. (2) For the purposes of clause 77 (f) of the Act, the following are the other areas on which information shall be provided:
1. Resident safety, including information on reporting incidents, accidents and missing residents, and information on wheelchair safety. O. Reg. 79/10, s. 223 (2).

2. Emergency and evacuation procedures. O. Reg. 79/10, s. 223 (2).
3. Escorting residents. O. Reg. 79/10, s. 223 (2).
4. Mealtime assistance, if the volunteer is to provide such assistance. O. Reg. 79/10, s. 223 (2).
5. Communication techniques to meet the needs of the residents. O. Reg. 79/10, s. 223 (2).
6. Techniques and approaches to respond to the needs of residents with responsi

Findings/Faits saillants :

1. The licensee failed to ensure that every volunteer received the orientation provided for in section 77 of the Act. For the purpose of section 77 of the Act, every licensee of a long-term care home shall develop an orientation for volunteers that included information on,

(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) the duty to under section 24 to make mandatory reports;
(e) fire safety and universal infection control practices;
(f) any other areas provided for in the regulations; and
(g) the protection afforded by section 26.

A. CIS log #034473-16 identified that a volunteer reported an allegation of staff to resident abuse to the ADOC on an identified date in December, 2016, which was reported to the volunteer by the resident on an identified date in December, 2016. On

identified date in January, 2018, the RPM was interviewed and indicated volunteers received an orientation package, which contained direction on reporting of alleged abuse of residents, during Volunteer Appreciation day, and they were to sign the sheet confirming that they received the information. The RPM confirmed that the volunteer, who reported the incident, did not sign the sheet indicating that they received the orientation package. On an identified date in January, 2018, the volunteer, who reported the incident, was interviewed and confirmed that they received the orientation package but did not sign at the time when they received it and they did not read it yet. The volunteer also indicated that they were not aware about requirements of mandatory reporting to the Director. On an identified date in January, 2018, the RPM indicated that the home did not ensure that every volunteer received the orientation provided for in section 77 of the Act, which was acknowledged by the Administrator.

Please note: this non-compliance was issued as a result of CI log #034473-16, which was conducted concurrently with the RQI.

B. The Critical Incident log #034473-16 related to staff to resident #010 alleged physical abuse was submitted by the home on an identified date in December, 2016. On an identified date in January, 2018, the Resident Program Manager indicated that the Extendicare Volunteer Handbook and Volunteer Essentials – Orientation and Training information were provided in May 2017 during Volunteers Appreciation day to volunteers, who attended the meeting. On an identified date in January, 2018, the Inspector reviewed the orientation package information and the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26, that was whistle-blowing protection, were not included in the orientation package provided. On an identified date in January, 2018, the RPM realized that the Extendicare Volunteer Handbook and Volunteer Essentials - Orientation and Training information in orientation package provided to the volunteers did not include the required information. The RPM identified that the Extendicare Volunteer Handbook previously developed by Extendicare, which included all information required in section 77 of the Act, should have been provided to volunteers, which was acknowledged by the Administrator.

The home did not ensure that every volunteer received the orientation provided for in section 77 of the Act.

Please note: this non-compliance was issued as a result of CI Log # 034473-16, which was conducted concurrently with the RQI. [s. 223. (1)]

2. The licensee failed to ensure that for the purposes of clause 77 (f) of the Act, the following were the other areas on which information should be provided: 6. Techniques and approaches to respond to the needs of residents with responsive behaviors.

The CI log #034473-16 related to staff to resident #010 alleged physical abuse was submitted by the home on an identified date in December, 2016. On an identified date in January, 2018, the RPM indicated that the Extendicare Volunteer Handbook and Volunteer Essentials – Orientation and Training information were provided in May, 2017, during Volunteers Appreciation day to volunteers, who attended the meeting. The Inspector reviewed the orientation package information and identified that techniques and approaches to respond to the needs of residents with responsive behaviors were not included in the orientation for volunteers, which was confirmed by the RPM, who indicated that the wrong package was provided to the volunteers, which was acknowledged by the Administrator.

The home did not ensure that information related to techniques and approaches to respond to the needs of residents with responsive behaviors was included in the orientation for volunteers working in the home.

Please note: this non-compliance was issued as a result of CI log #034473-16, which was conducted concurrently with the RQI.

Issued on this 23rd day of February, 2018

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

Original report signed by the inspector.