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
Jul 3, 2018	2018_718604_0004	005356-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Kennedy Lodge
1400 Kennedy Road SCARBOROUGH ON M1P 4V6

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

SHIHANA RUMZI (604), BAIYE OROCK (624), CRISTINA MONTOYA (461), SAMI JAROUR (570)

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): April 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, and 27, 2018.

The following intakes were inspected concurrently with the Intensive Resident Quality Inspection:
Critical Incident System (CIS) Report intakes related to alleged abuse:
Log #005219-16
Log #0064540-16

Log #007187-16
Log #026565-16
Log #022038-17

Critical Incident System (CIS) Report intakes related to falls:
Log #028544-16
Log #015811-17
Log #005725-17

Complaints related to alleged abuse:
Log #016666-16
Log #020596-17

Complaints related to communication lacking:
Log #007844-17

Complaints related to pest control:
Log #011779-17

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Acting Director of Care (ADOC), Food Services Supervisor (FSS), Food Services Manager (FSM), Environmental Services Manager (ESM), RAI-Coordinator (RC), RAI-Coordinator Backup (RCB), physiotherapist (PT), Registered Dietitian (RD), Prisha Law firm (PL), Housekeeper (HK), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Worker (FSW), Program Aide (PA), Translator, Residents, Substitute Decision Makers (SDMs), Presidents of Resident's and Family Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: medication administration and storage area, staff and resident interactions, provision of care, conducted reviews of health records, and critical incident log, staff training records, meeting minutes of Residents' and Family Council meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee had failed to ensure that the written care plan for each resident, sets out the planned care for the resident.

The home submitted a Critical Incident System (CIS) report on an identified date to the Ministry of Health and Long Term Care (MOHLTC), Director. The CIS report indicated resident #011 was transferred to hospital with a significant change in status. The CIS report further stated a PSW found the resident lying on the floor. The resident was assessed and was found to have sustained injuries and complained of pain. The resident was transferred to hospital for further assessment.

A review of resident #011's admission notes indicated the resident was admitted to the home on an identified date with identified medical diagnosis.

Documentation review of resident #011's health records as carried out for an indicated time period. The Community Care Access Center (CCAC) Minimum Data Set Home Care (MDS-HC) assessment indicated that resident #011 had an identified number of falls within the identified time period and had been identified at risk for falls.

A review of resident #011's written plan of care for an identified review period revealed that the plan of care did not include a falls focus and did not identify fall risks for resident #011.

On an identified date, RN #118 completed the Falls Risk Assessment Tool (FRAT) for resident #011 and identified that the resident was at risk of falls.

A review of the progress notes for resident #011 for an identified period of time was carried out and revealed the following:
-On an identified date and time, RN #118 documented, in an admission progress note, that resident #011 had a fall, and sustained an injury and the resident used a identified ambulation device which would be supplied by the residents Substitute Decision Maker (SDM).
- On an identified date and time, Physiotherapist (PT) #127 documented, in a progress note, that resident #011 required minimal assistance for transfers. That the resident was able to use an identified ambulation device and that the resident was at moderate risk of falls.
- On an identified date and time, resident #011 had an unwitnessed fall. The resident

sustained injuries and complained of pain and the resident was sent to hospital for further assessment.

An interview was carried out on an identified date, with PSW #124 who indicated resident #011 required supervision with setup assistance when the resident was admitted and the resident was not at risk of falls.

An interview was carried out on an identified date, with RN #118. The RN indicated resident #011 was at low risk of falls and the resident needed setup assistance with identified mobility devices. The RN stated that the resident refuses to ask for assistance and further indicated that falls prevention interventions for resident #011 should have included identified interventions. The RN and the inspector reviewed the written plan of care and the RN acknowledged that the above interventions where not captured in the residents written plan of care.

An interview was carried out on an identified date, with the PT #127, indicated that resident #011 was assessed at moderate risk of falls related to balance and use of mobility aids. The PT stated that on admission to the home the resident utilized identified mobility aids and after their assessment by the PT they recommended the resident use a different mobility device.

An interview was carried out on an identified date, with the home's ED who indicated that when a resident is admitted to the home and are assessed as being at low risk of falls, universal falls prevention interventions are put in place. The ED reviewed the written plan of care with the inspector and acknowledged that the written plan of care for resident #011 did not identify the planned care for the resident with respect to their risk of falls.

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 written plan of care for each resident, sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee had failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.

The initial tour of the home was conducted on an identified date, and Inspector #624 observed the following:

-At an identified time and floor, the inspector was able to push the Exit Door open which lead to the stairwell and triggered the alarm. Housekeeper (HK) #102 and Personal Support Worker (PSW) #103 who were near the door at the time, responded, deactivated the alarm, shut the door, and tried opening the door again which would not lock as required. Both the HK and the PSW indicated that the door should be locked at all times as residents should not have access to the stairwell. The PSW notified the Environmental Service Manager (ESM) and returned to safeguard the door.

-At an identified time and floor, the inspector was able to push the Fire Exit Door open and the alarm activated. The inspector followed the stairs that led to another door which opened to the exterior of the building. This second door was locked and secured. PSW #104 responded to the alarm and indicated to the inspector that the door should be locked at all times. The PSW notified their supervisor, Registered Nurse (RN) #105 who indicated that the door had not been locked for some time but should be locked at all times to prevent resident access to the stairwell. RN notified the ESM of the concern.

Interviews were conducted on an identified date with the home's ESM and Executive Director (ED) related to the inspectors above observations. The ED and ESM acknowledged that the Fire Exit Door on the two identified floor of the home should have been locked at all times.

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 doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked, 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

Findings/Faits saillants :

The licensee had failed to ensure that there was place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The home's policy "LTC - Management of Concerns, Complaints, and Compliments", index: ADMIN3-O01.01, modified date of October 2017, under "Verbal Concerns, Comments" it stated under bullet three where a complaint alleges harm or risk of harm to one or more residents an investigation shall commence immediately. This will be considered an allegation or suspect of abuse or a care/treatment error and will be documented in RMM/QIA and not document on a CSR log. In the policy under "Reporting and Submission Requirement", refers to LTC Act 2007, s. 21 where the LTC home shall immediately forward the concern to the Centralized Intake, Assessment and Triage Team (CIATT), MOHLTC. A copy of the response to the complainant and actions taken to resolve the complaint will be forwarded to the Director within 10 business days.

The MOHLTC ACTIONline received a complaint on an identified date. The complainant indicated a number of care concerns related to staff not able to understand resident #047 due to a language barrier.

Inspector #604 conducted an interview on an identified date, with the support of translator #125 with resident #047.The resident started out by expressing to the inspector

that there is a language barrier between them and the staff at the home. The resident was unable to recall the date but the incident occurred on an identified shift where they rang the call bell for assistance and a PSW entered the room and was not able to understand what the resident wanted. The resident further indicated the PSW became loud and was rude to them and the resident reported to their SDM of the incident.

Inspector #604 conducted a telephone interview on an identified date, with resident #047's SDM #126. The SDM stated resident #047 did inform them of an incident which occurred on an identified shift but indicated they are unable to recall the date. The SDM indicated the resident stated the PSW was loud and rude during the care and had reported the concern to RN #129 on an identified shift and has not heard anything further about the concern.

Inspector #604 conducted an interview with RN #129, who acknowledged that they were made aware of the incident on an identified shift, by the SDM of resident #047. The RN stated they were informed that an identified shift that a PSW was rude to the resident which made the resident feel upset. The RN stated they documented the concern which was to be followed up with an identified shift RN. The RN stated the incident was not reported to the home and not investigated.

Inspector #604 conducted an interview with RN #120, and they acknowledged that they were aware of the incident above which was documented on an identified floor. The RN confirmed the incident was not reported to the home and not investigated.

Inspector #604 conducted an interview with the home's ED who stated that management was unaware of the above incident which involved resident #047, until they were informed of the incident by the Inspector. The Administrator acknowledged the RN staff are able to call the MOH After hour's line to report allegations of abuse as there trained on the home's policy and the home's complaint reporting policy was not followed.

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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

The licensee had failed to ensure that strategies were developed and implemented to meet the needs of the residents who cannot communicate in the language(s) spoken in the home.

The MOHLTC ACTIONline received a complaint on an identified date. The complainant indicated a number of care concerns related to staff not able to understand resident #047 due to a language barrier.

A telephone interview was carried out with resident #047's SDM #126. The SDM stated all concerns that they have are related to the care of resident #047 are in response to lack of communication methods between the resident and staff. The SDM stated staff are unable to care and assess the resident's needs as they are unable to understand each other. The SDM indicated that the resident is unable to understand the English language, however has supplied the home with a sheet of paper with translated words which is kept in the resident's room. The SDM indicated that they were uncertain if all staff take the time to look at the paper as the resident has indicated to the SDM that staff do not refer to the paper. The SDM stated they have brought these concerns to the home's attention but they were not sure who they spoke to. In closing, the SDM stated they have

spoken to CCAC to move resident #047 to a more fluent in their home language.

Inspector #604 conducted an interview with the support of translator #125 with resident #047.The resident indicated to the inspector that there is a language barrier between them and the staff at the home. The resident stated that during an identified period of time and on an identified shift they needed assistance. The resident rang the call bell, and the nurse came in and had tried to communicate with them but the nurse did not understand their body language. The resident indicated that at the time they had to state, "telephone" and their SDM's name. The resident called the SDM who then told the nurse to call the ambulance as the resident needed to go to the hospital. The resident stated the incident made them feel "scared" and indicated that an indicated shift was the worse for communication as there is no one who can understand their needs.

The sample size was increased due to the concern of language barrier identified with resident #047.

Inspector #604 conducted an interview, with the support of translator #125 with resident #035. The translator spoke to the resident and then stated resident #035 spoke a different dialect that they were not able to translate. The translator attempted to communicate once again with resident #035 with no success.

Inspector #604 conducted a telephone interview with the resident #035's family member and they indicated they visit resident #035 daily. The family member stated resident #035 speaks an identified language and the SDM understands the resident. The family member stated the staff and resident have a communication barrier and there was no methods for communication created by the home to communicate with the resident other than calling the SDM for translation.

Interviews were conducted with PSW #128 and Registered Practical Nurse (RPN) #129 on an identified floor. The staff stated that the residents in the home spoke a predominant language. The staff stated they are able to get a staff to translate to English if needed on two identified shift. The staff stated that they care for resident #047 and the resident is unable to understand English. The staff indicated that they use gestures and body language with the residents but the methods are not affective all the time and the SDM is often called for translation. The staff acknowledged that strategies were not developed and implemented to meet the needs of all resident who cannot communicate in the language spoken by the resident.

Interviews were conducted with PSW #121 and RPN #146, and RN #150 and PSW #151 on an identified dates and floor of the home. The staff indicated most residents speak an identified language and most of the staff in the home speak English. The staff stated they know resident #035 and there is a language barrier as resident #035 speaks minimal English and the resident's SDM assists with translation. Staff stated they communicate with the resident by using gestures, signs, and pointing at things in the resident's room to assist the resident with their needs and acknowledged that strategies were not developed and implemented to meet the needs of residents who are unable to communicate in the language spoken by the residents.

Inspector #604 conducted an interview with the home's ED who indicated the spoken language in the home by staff is English and the language spoken by most of the residents was not English. The ED stated the staff in the home can utilize identified staff in the home to translate for residents. The ED further acknowledged that communicating with resident #047 was difficult. The ED stated resident #035 spoke minimal English and the family could communicate with the resident. The ED stated for both residents the staff communicate with gestures, sings, and also using simple. The ED acknowledged that strategies had not been developed and implemented to meet the needs of all the residents who were not able to communicate in the language spoken in the home.

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 strategies were developed and implemented to meet the needs of the resident who cannot communicate in the language spoken in the home, 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).

Findings/Faits saillants :

The licensee had failed to ensure that staff participated in the implementation of the infection prevention and control program.

On an identified date, Inspector #604 conducted a lunch meal service observation on an identified floor.

During the lunch meal observation the inspector observed Food Services Worker (FSW) #107 pick up four clean soup bowls with their fingers inside the bowls, place them on the server, and pour the minestrone soup and congee in the bowls. The inspector spoke to the FSW as PSW #121 picked up the soup bowls to deliver to table number nine. The FSW asked the PSW to bring the four soup bowls back.

Inspector #604 conducted an interview with FSW #107. The FSW indicated they were educated to handle the soup bowls with the handles as and confirmed that they placed their fingers inside the four soup bowls when they picked up the bowls and it was not a proper infection control practice. The FSW indicated they had not performed hand hygiene prior to handling the clean soup bowls.

Inspector #604 conducted an interview with Food Service Supervisor (FSS) #123. The inspector informed the FSS of their observation during the lunch meal service on the second floor. The FSS indicated the FWS did not practice proper infection control practices by placing their fingers inside the soup bowls when they pick them up.

2. Inspector #461 carried out a follow-up lunch meal observation on an identified date and floor of the home. During the lunch meal observation the inspector observed the following:

-PSW #141 cleared the dirty soup bowls from all the tables, then proceeded to touch their nose and hair, and then sit down and feed resident #023 without performing hand hygiene between tasks. The PSW then proceeded to pick up clean hand wipes and distribute them to the residents seated at the tables.

-At an identified time, PSW #141 was feeding resident #024 at an identified table in the dining room and then moved onto table another identified table to assist resident #025 with feeding without completing hand hygiene between residents.

An interview was carried out with PSW #141who indicated hands are to be cleaned when going from dirty to clean tasks as per the home's infection prevention and control practices. The PSW was informed of the inspectors above observations and the PSW stated that the meal service was too busy and acknowledge that they did not perform proper hand hygiene.

Interviews were carried out with the FSS #109 and the Director of Care (DOC). They both indicated staff members were expected to perform hand hygiene before and after entering the dining room and when transitioning from dirty to clean tasks. The DOC indicated that staff were expected to wash their hands after having contact with dirty dishes, in-between assisting residents with feeding, and when moving from table to table. The DOC acknowledged that wipes did not substitute as hand hygiene, and PSW #141 did not follow the home's process for hand hygiene practices in the dining room.

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 staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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 :

The licensee had failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or by the licensee or staff that resulted in harm or risk of harm occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

The home submitted a CIS report on an identified date to the MOHLTC. The CIS report indicated that resident #034 had reported to registered staff that PSW #140, while assisting the resident on an identified date and location of the home, and was rough with the resident causing the resident injuries.

A review of the licensee's investigation package revealed an email correspondence from an identified shift Manager RN #139, related to the incident and that the incident had been reported to them on an identified date and time. RN #139 indicated that upon assessment of resident #034, the resident stated that PSW #140 was rough and on an identified date and location of the home.

In separate interviews conducted with shift Manager RN #139 and the ED both indicated that the licensee's expectation is that all alleged or witnessed incidents of abuse shall be reported immediately to the Director. The identified shift manager further indicated that after the alleged abuse incident was reported to them, they had reassigned PSW #140 with close supervision by the Nurse Manager as it was not safe to send the PSW home

at the time of the incident. Both indicated that the above incident was not reported immediately to the Director as the incident had occurred on an identified date and time and was not reported to the Director until later that day. There was also no indication the MOHLTC after-hours line was called related to this incident. The ED stated PSW #140 had transitioned to a casual position, and has not accepted a shift in the home since the incident and was not available for interview.

2. The home submitted a CIS report on an identified date to the MOHLTC Director. The CIS report indicated at an identified time, a PSW heard a noise while they were in another room providing care. The PSW responded to the noise which came from an identified room, and witnessed resident #012 holding an identified object and exhibiting an identified responsive behaviour toward another resident. The PSW immediately removed the identified piece of equipment from resident #012 and the PSW removed resident #013.

During a review of resident #012's health records the inspector noted a progress notes, which indicated two separate incidents of an identified responsive behaviour had occurred between resident #015 and #012, who had an identified Cognitive Performance Score (CPS) and resident #012 with an identified CPS. The identified dates of the incidents indicated the following:
-On an identified date and time, RN #144 witnessed resident #015 present with an identified responsive behaviour towards resident #012 in an identified location of the home. RN #144 removed resident #012 and separated both residents. The DOC and Acting Director of Care (ADOC) #153 were informed of the incident immediately by the RN. Both residents were monitored closely for safety as per DOC.

-On an identified date and time, RN #144 noted resident #015 once again presented with an identified responsive behaviour towards resident #012 in an identified location of the home. The residents were separated immediately and informed to stay away from each other. ADOC #153 was informed immediately of incident and resident #015 was monitored for an identified duration of time.

Interviews were conducted with the DOC and ADOC #153. The DOC and ADOC was informed of the two incidents of an identified responsive behaviour between resident #012 and #015, which were not reported to the Director. Both the DOC and ADOC indicated there were not aware of the second incident which had occurred on an identified date and time. The DOC indicated video footage was reviewed and the incident was initiated by resident #015 and the SDM's of both residents were notified of the

incident that occurred on an identified date and time. The DOC further indicated that there was no documentation to indicate whether the two incidents of an identified responsive behaviour were consensual or not.

Issued on this 16th day of July, 2018

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

Original report signed by the inspector.