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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 16, 2015	2015_200148_0002	O-00895-14	Critical Incident System

Licensee/Titulaire de permis

MAXVILLE MANOR
80 Mechanic Street MAXVILLE ON K0C 1T0

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

MAXVILLE MANOR
80 MECHANIC STREET WEST MAXVILLE ON K0C 1T0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 7 and 9, 2015, on site.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Staff Development Coordinator, Registered Nursing Staff and Personal Support Workers. In addition, the Inspector reviewed the resident health care record, staffing schedules, the home's investigation file related to the identified incident, the home's policy to promote zero tolerance of abuse and neglect and data related to the training and education of staff related to the abuse policy.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **1 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. 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, is complied with.

As identified by the home's DOC, the policy titled "Abuse/Neglect of Residents/Clients", is the policy that promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act.

The policy indicates that any person who has reasonable grounds to suspect that abuse and/or neglect of a resident shall immediately report the suspicion and information upon which it is based to the Supervisor in charge. The Supervisor in charge will immediately contact the Executive Director or designate.

On a specified date, Resident #1 was seated in a wheelchair and propelling him/herself around the unit, when PSW Staff member #S102 witnessed PSW Staff member #S101 to grab the handles of the wheelchair from behind and pull the wheelchair backwards. The resident stood up in response and PSW #S101 wrapped her arms around the resident from behind. PSW #S102 recalls that PSW #101 struggled with the resident from behind attempting to make the resident sit back down in his/her wheelchair, while shouting profanities at the resident. The resident, who is cognitively impaired and not able to recollect the events, was not injured during the incident and progress notes indicate that the resident's behaviours were escalated during the afternoon and evening shifts of the same date.

PSW #S102, did not report the incident to a supervisory staff member until twenty days after the incident, when she made a report of the incident to RPN #S103. RPN #S103 reported the incident to the home's DOC three days after the PSW's report, at which time the DOC immediately began an investigation and suspended PSW #S101 pending the investigation. Three days after the DOC initiated the investigation, the home's DOC completed the investigation into the alleged incident of abuse, concluding that verbal abuse had occurred and in response the employment of PSW #S101 was terminated.

Staff members, including supervisory staff members did not follow the home's policy to promote zero tolerance of abuse and neglect, as it relates to the internal reporting structure when a person has reasonable grounds to suspect that abuse of a resident has occurred. [s. 20. (1)]

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports and contains procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

As identified by the home's DOC, the policy titled "Abuse/Neglect of Residents/Clients", is the policy that promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act.

The policy describe the home’s internal process of completing mandatory critical incident reports to the Ministry of Health and Long Term Care.

As per the home's policy, “Any person who has reasonable grounds to suspect that

abuse and/or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which the suspicion is based to the Supervisor in charge. The Supervisor in charge will immediately contact the Executive Director who will concurrently complete a mandatory critical incident report to the Ministry of Health and Long Term Care.

The policy to promote zero tolerance of abuse and neglect of residents does not include an explanation of the duty under section 24, for all persons, to make mandatory reports to the Director, as defined by section 2 (1) of the Act. [s. 20. (2)]

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 policy to promote zero tolerance of abuse and neglect of residents contains all requirements as outlined by both section 20 of the Act and section 96 of the Regulations and that the policy is complied with, to be implemented voluntarily.

WN #2: 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. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Regulation 79/10, s.2(1), emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Regulation 79/10, s.2, verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On a specified date, Resident #1 was seated in a wheelchair and propelling him/herself around the unit, when PSW Staff member #S102 witnessed PSW Staff member #S101 to grab the handles of the wheelchair from behind and pull the wheelchair backwards. The resident stood up in response and PSW #S101 wrapped her arms around the resident from behind. PSW #S102 recalls that PSW #101 struggled with the resident from behind attempting to make the resident sit back down in his/her wheelchair, while shouting profanities at the resident. The resident, who is cognitively impaired and not able to recollect the events, was not injured during the incident and progress notes indicate that the resident's behaviours were escalated during the afternoon and evening shifts of the same date.

Twenty days after the incident, PSW #S102 informed supervisory staff member RPN #S103 of the alleged incident of abuse that occurred. Three days after the report from the PSW, RPN #S102 approached the home's DOC with a written copy of the information, as known to her, about the incident. On the same date, PSW #S102 provided a written statement via email, to notify the DOC of the alleged incident of abuse.

The home's DOC immediately began an investigation and suspended PSW #S101 pending the investigation. The investigation concluded that verbal abuse had occurred and in response the employment of PSW #S101 was terminated.

Nineteen days after the conclusion of the home's investigation, a Critical Incident Report

(CIR) was completed and submitted by the home's DOC, as the report to the Director. Inspector #148 confirmed with the DOC that no other manner of report was made to the Director. Further to this, both PSW #S102 and RPN #S103 confirmed that no manner of report was made to the Director by either staff member who both had knowledge of an alleged incident of abuse. [s. 24. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;

2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee did not ensure that the package of information, given to every resident and substitute decision maker at the time of admission, includes at a minimum the long term care home's policy to promote zero tolerance of abuse and neglect of residents.

As identified by the home's DOC, the policy titled "Abuse/Neglect of Residents/Clients", is the policy that promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act.

As reviewed in the presence of the home's DOC, the package of information provided to every resident and substitute decision maker at the time of admission, does not include the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 78. (2) (c)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that required information, including the home's policy to promote zero tolerance of abuse and neglect of residents, are posted in the home.

Upon the Inspector's entrance to the home on January 7, 2015, the Inspector met with the home's Administrator and requested the home's policy to promote zero tolerance of abuse and neglect of residents. The Administrator indicated that the home's policy would be posted on the bulletin board located across from the chapel, where other required postings are located.

At approximately 10:00am, the Inspector observed the postings in the home and was unable to locate a posting of the home's abuse policy. The bulletin board across from the chapel had a sign that stated the policy for abuse can be requested by contacting the home's DOC. The Inspector was approached by the home's Staff Development Coordinator at approximately 10:15am with a copy of the home's abuse policy and indicated that she had reposted the policy on the bulletin board. Later in the day the Inspector confirmed the policy titled "Abuse/Neglect of Residents/Clients" was posted.

As identified by the home's DOC on January 9, 2015, the policy titled "Abuse/Neglect of Residents/Clients", is the policy that promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act.

During initial observations of postings in the home, this policy was not posted as required by section 79 of the Act. [s. 79. (3) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains all requirements of section 96 of the Regulations.

As identified by the home's DOC, the policy titled "Abuse/Neglect of Residents/Clients", is the policy that promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act.

The policy does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

The policy indicates that staff members suspected of committing any abuse and/or neglect of a resident will be suspended without pay immediately and that final disciplinary actions will be made by the Administrator. The policy does not contain procedures and interventions to deal with persons, other than staff members, who have abused or neglected or allegedly abused or neglected residents, as appropriate.

The policy does not identify the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation.

The policy does not identify the training and retraining requirements for all staff as described by section 96(e)(i) and (ii). [s. 96. (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee failed to ensure that the resident's substitute decision maker (SDM) was notified within 12 hours upon becoming aware of an alleged incident of abuse of Resident #1.

In accordance with O.Regulation 79/10, s.2(1), emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Regulation 79/10, s.2, verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On a specified date, Resident #1 was seated in a wheelchair and propelling him/herself around the unit, when PSW Staff member #S102 witnessed PSW Staff member #S101 to grab the handles of the wheelchair from behind and pull the wheelchair backwards. The resident stood up in response and PSW #S101 wrapped her arms around the resident

from behind. PSW #S102 recalls that PSW #101 struggled with the resident from behind attempting to make the resident sit back down in his/her wheelchair, while shouting profanities at the resident. The resident, who is cognitively impaired and not able to recollect the events, was not injured during the incident and progress notes indicate that the resident's behaviours were escalated during the afternoon and evening shifts of the same date.

Twenty-three days after the incident the home's DOC was notified by both PSW #S102 and RPN #S103, of the incident as described above. The DOC immediately began an investigation and suspended PSW #S101 pending the investigation.

Three days after the initiation of the investigation, the home's DOC completed the investigation into the alleged incident of abuse, concluding that verbal abuse had occurred and in response the employment of PSW #S101 was terminated.

Critical Incident Report (CIR) #C540-000005-14, was submitted by the home's DOC to the Director (MOHLTC). The CIR indicates that the SDM is "to be contacted by writer". Upon further questioning of the DOC it was determined that the SDM for Resident #1 was not notified of the alleged incident of abuse or that the home had initiated, conducted and concluded an investigation into an alleged incident of abuse, until nineteen days after the home concluded the investigation. [s. 97. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report to the Director, under section 23(2) of the Act, is made in writing within 10 days of becoming aware of the alleged, suspected or witnessed incident.

In accordance with LTCHA 2007, s.23(2), the licensee shall report to the Director the results of every investigation undertaken for every alleged suspected or witnessed incident of abuse of a resident by anyone, and every action taken in response to such an incident. Further to this O.Regulation 79/10 s.104 describes the contents of the written report and the time frame, in which the written report is required by the Director.

In accordance with O.Regulation 79/10, s.2(1), emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Regulation 79/10, s.2, verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On a specified date, Resident #1 was seated in a wheelchair and propelling him/herself around the unit, when PSW Staff member #S102 witnessed PSW Staff member #S101 to grab the handles of the wheelchair from behind and pull the wheelchair backwards. The resident stood up in response and PSW #101 wrapped her arms around the resident from behind. PSW #S102 recalls that PSW #101 struggled with the resident from behind attempting to make the resident sit back down in his/her wheelchair, while shouting profanities at the resident. The resident, who is cognitively impaired and not able to recollect the events, was not injured during the incident and progress notes indicate that the resident's behaviours were escalated during the afternoon and evening shifts of the same date.

Twenty-three days after the incident, the home's DOC was notified by both PSW #S102 and RPN #S103, of the incident as described above. The DOC immediately began an investigation and suspended PSW #S101 pending the investigation. Three days after the initiation of the investigation, the home's DOC completed the investigation into the alleged incident of abuse, concluding that verbal abuse had occurred and in response the employment of PSW #S101 was terminated.

Nineteen days after the home concluded the investigation, a Critical Incident Report (CIR) was completed and submitted by the home's DOC, as the written report to the Director. Inspector #148 confirmed with the DOC that no other manner of written report was made to the Director previous to August 27, 2014. [s. 104. (2)]

Issued on this 16th day of January, 2015

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

Original report signed by the inspector.