Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 29, 2014	2014_200148_0012	O-000284-14	Resident Quality Inspection

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), JOANNE HENRIE (550), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 14-17 and April 22 -25, 2014, on site.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Director of Environmental Services (DES), Staff Development Director, Assistant Administration, Registered nursing staff, Personal Support Workers (PSW), Housekeeping aids, Food Service Workers, family and residents.

During the course of the inspection, the inspector(s) reviewed several resident health care records including plans of care, medical orders and flow sheets. Policies and procedures were reviewed including those related to the medication management system, trust accounts, restraints, collection of resident body weight and heights, labeling of personal items, infection control, housekeeping and maintenance. In addition, meal service and staff resident interaction and medication administration were observed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.15(2)(c), whereby the licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On April 16, 2014, Inspector #547 observed the B wing resident dining room, to have two ventilation system boxes near the floor that were rusted, paint scratched and with floor plates missing under the boxes with visible food debris and other material.

On April 16, 2014, Inspector #547 observed damage to the bottom of resident bedroom doors including missing paint and wood chips, exposing non-sealed wood surfaces in several areas which has not been maintained to provide for a surface that is able to be cleaned and sanitized.

Throughout the home, Inspectors observed that drawers for personal care equipment located in resident bathrooms were missing the laminate surface that lines the base of the drawers, exposing porous material which has not been maintained to provide for a surface that is able to be cleaned and sanitized.

On April 22, 2014, Inspector #547 observed Resident #534's commode in the resident's bathroom, to have old stains and areas of yellow/brown rust on the metal bars and wheels brakes. Inspector interviewed Housekeeping aid #S104, who indicated that resident commodes are cleaned daily with regular toilet cleaning. Housekeeping aid #S104 further reported that commodes with rust should be reported to the DES, the staff member was not aware if the damage to Resident #534's commode had been reported. Inspector #547 spoke with the DES, who in the company of the Inspector observed the commode for resident #534. He reported that commodes are to be cleaned during complete cleaning of resident rooms, which the DES indicated would be weekly. The DES reported that it is his expectation that staff would report damage to commodes, as seen on resident #534's commode. After the DES observed the commode he indicated that resident #534's commode requires repair or replacement. Further to this issue, Inspector #547 and the home's DES observed resident #559's commode located in the resident's bathroom, which was also observed to have rust on the metal bars and wheel brakes. The DES indicated that this commode requires replacement and could not be properly cleaned by housekeeping staff.

In the company of the DES, Inspector #547 observed Resident #534's bedroom to have chipped walls including missing drywall, one area of the bathroom door frame

was observed to have missing drywall exposing the metal corner framing of the door. The DES indicated that rooms with such damage as described above, do not usually get plastered, repaired or painted until the resident no longer resides in the room.

In the company of the DES, Inspector #547 observed Resident #559's bedroom, where it was observed that the electrical outlet, with a 3 prong electrical cord plugged into it, had a broken face plate, creating several sharp edges. In addition, the electrical outlet did not sit flush with the wall, preventing the prongs of the electrical cord to be plugged in properly. The DES indicated the damage to the electrical outlet should have been reported by staff and is in need of repair. Within this resident's bedroom, damage at the head of the bed near the side rial was also observed whereby the drywall was damaged with holes, scrapes and paint missing. The DES indicated this type of damage should be flagged as a priority for repair. The DES confirmed that he was unaware of the damage to the wall caused by the side rail. Also, it was noted that the wooden window sill in this resident room was not attached securely whereby the Inspector could move the sill in a downward motion. The DES indicated that this is likely water damage due to the fact that a window air conditioner was previously located in this window.

In the company of the DES, Inspector #547 observed Resident #577's bedroom to have chipped walls including missing drywall, one area of the bathroom door frame was observed to have missing drywall exposing the metal corner framing of the door, which was bent outward posing a risk of injury for the resident. The DES indicated that this area requires repair as soon as possible due to risk for injury. The DES confirmed that he was not aware of the damage to this door frame. [s. 15. (2) (c)]

2. Over the course of this inspection the following was observed by Inspector #148, within the BC unit:

Damage to the baseboards in both the Stormont and Glengarry hallways, including scrapes of painted surface that runs the entire span of the hallway and there was also peeling/cracking of caulking along the baseboard creating crevices for dirt and debris to gather.

Within the Stormont and Glengarry hallways, multiple areas were noted whereby the caulking has peeled away or cracked along the particleboard that is used to affix the handrail. At an area across from room 231 and outside room 232, the described particle board was not affixed to the wall and can be pulled approximately one inch off

the wall creating crevices for dirt and debris to gather. Two areas were also identified in which the protective surface of the particle board was missing, exposing a porous surface, which has not been maintained to provide for a surface that is able to be cleaned and sanitized.

Within the Stormont and Glengarry hallways the protective surface, that is glued to the wall between the handrail and baseboard, was peeling away from the wall. Across from room 224 an entire piece of protective surface was missing exposing a rough, dried glue surface.

Within the Stormont hallway, the utility room doors and bathing centre door, including door trim, have multiple areas of missing paint whereby a metal surface is exposed.

Within the Stormont hallway, on the wall near the bathing center door, there was an area where both the paint and surface of drywall is peeled away exposing porous drywall, the area measuring 5-8 inches long, which has not been maintained to provide for a surface that is able to be cleaned and sanitized.

Damage to both the B and C dining room was observed, whereby the caulking between the floor and baseboard is peeling, cracked or missing in multiple areas, allowing for an area to exist that cannot be cleaned and sanitized as needed. Within this described area there was visible food, dust and other unidentifiable debris. An addition area was noted in the B dining room near one corner of the room where a floor tile is missing exposing the porous plywood subfloor, which has not been maintained to provide for a surface that is able to be cleaned and sanitized. [s. 15. (2) (c)]

3. During an observation on April 16, 2014, Inspector #550 observed the lounge in hallway E. Several indentations were noted in the drywall behind the rocking chair and beside the love seat and the facing and the backing of the door from the lounge was coming apart, which has not been maintained to provide for a surface that is able to be cleaned and sanitized.In addition, the ceiling has a large water stain.

The DES reported that the home's expectation is for staff to report to the environmental services department, when areas of the home require repair or replacement. The DES confirmed that no formal audits are done related to the environmental services program. (#547) [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 17(1)(a) and (d), where by the licensee failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times and is available at each bed location.

On April 16, 2014, Inspector #547 observed the resident-staff communication system in the bedroom of an identified resident, to be located in the corner of the room near the head of the bed. The cord, attached to the resident-staff communication system, reaches to the bed side rail. On April 24, 2014, Inspector #547 observed the identified

resident in the resident's room, sitting in his/her wheelchair. The cord, described above, could not reach the resident. When interviewed by Inspector #547, the resident reported that he/she requires staff assistance for care, including toileting. The Inspector inquired as to how the resident would call for assistance when needed, the resident indicated he/she "would go down the hall to ask the nurse for help". [s. 17. (1)]

2. During the course of this inspection, Inspector #148 observed in several resident bedrooms on the BC unit, including rooms 227, 325, 326, 327 and 330, in which the resident-staff communication system was located in an area away from the resident's bed and the cord attached to the communication system was not long enough to reach the location of the resident's bed.

Inspector #148 observed several resident rooms, including rooms 231, 232, 233 and 228 on the BC unit in which the resident-staff communication system is located in the corner of the room behind the resident bed. Due to furniture placement and the length of cord attached to the communication system, the resident-staff communication system was not easily accessible to residents, staff and visitors.

On April 15, 2014, Inspector #148 observed Resident #600, to be in the resident's bedroom sitting in a comfortable easy chair, the resident did not have access to the resident–staff communication system, as the communication system is located on the opposite wall as the comfortable chair and the cord attached to the system was not long enough for it to be accessible to the resident. On the same date, Inspector #148 observed Resident #541 in the resident's bedroom seated in a wheelchair, the communication system is located behind the head of bed opposite where the resident was sitting. The cord attached to the communication system was too short for it to be accessible to Resident #541. [s. 17. (1) (a)]

3. On April 15, 2014 an identified resident, who has visual impairment was observed in the resident's room, by Inspector #550, sitting in a comfortable easy chair. The cord attached to the resident-staff communication system was laying on the floor several feet away from the resident. When asked, the resident told the Inspector that if he/she required assistance from staff he/she would call the home using the telephone situated within reach. A review of resident's plan of care, indicated that staff are to ensure that the call bell is within the resident's reach. [s. 17. (1) (a)]

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 resident-staff communication and response system can be easily seen accessed and used by resident, staff and visitors at all times and is available at each bed location used by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 37(1)(a), whereby the licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Throughout the course of this inspection several personal items including electric razors, disposable razors with visible hair, used deodorants, used toothbrushes and hair brushes with visible hair were observed in private resident rooms, unlabelled.

Upon further observations similar items were found in semi-private rooms including unlabelled toothbrushes, unlabelled used deodorants, unlabelled disposable razors with visible hair and unlabelled hair combs with visible hair. Items were found on the counter tops of shared bathrooms and/or resident bathroom drawers.

Inspector #148 spoke with registered nursing staff member #S100, who reported that the labelling of personal items is the responsibility of registered nursing staff in the home and is usually done on admission. Staff member #S100 reported that as time permits, labelling will be done as items are acquired. Staff member #S100 further indicated that resident eye glasses are not labelled but rather the eye glasses of each resident are described in the plan of care.

Inspector #148 spoke with registered nursing staff member #S102 who reported that although some personal items such as toothbrushes and deodorants are labelled with the resident's name using a dark marker, they do not usually label such items since these items are stored in bins, located in the tub room, that are labelled with each resident's name.

Observations of the unit tub rooms confirmed that within each tub room there were storage bins, each labelled with a resident name. Contained within the bins were personal items such as cuticle scissors, deodorant and hair brushes. Items were observed to have no label.

Inspector #148 spoke with the home's DOC, she reported that the home does not usually label personal items such as toothbrushes and deodorants as many residents have private rooms in this home and/or items are stored in labelled bins in the tub room. The DOC confirmed that the home does not have a process in place to label hearing aids or glasses. [s. 37. (1) (a)]

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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 136. (3) (a) and (b), whereby the licensee did not ensure that drugs were destroyed by a team acting together and composed of members as described by this section.

On April 24, 2014 the DOC reported to Inspector #550 that controlled substances, in original form, are removed from the home by a pharmacist from Medical Arts Pharmacy. The controlled substances are then taken off site, by the pharmacist, to be destroyed by Stericycle. The home does not ensure that controlled substance are destroyed by a team composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist.

Inspector #550 reviewed the Home's policy #3.05 'Narcotics and Controlled Drugs: Disposal'. The procedure in section 2. (c) indicates 'The pharmacist will destroy the medication in the presence of a nurse.'

On April 24, 2014 the DOC reported to Inspector #550 that all other drugs, in original form, are removed from the home by either a pharmacist or representative from Medical Arts Pharmacy. The drugs are then taken off site to be destroyed by Stericycle. The home does not ensure that all other drugs are destroyed by a team composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing and Personal Care.

Registered nursing staff #S100 and S106 reported to Inspector #550 during an interview that all medications to be destroyed, except for narcotics, are put in a white plastic pail which is kept in the medication room. The pail is returned to the pharmacy for destruction when it is full.

Inspector #550 observed medication in the pail to be sent for destruction, the medications were observed to be in their original form and packaging. [s. 136. (3) (a)]

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 drugs are destroyed by a team acting together and composed of members as outlined by this provision, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.31(2) 4. and 5., whereby the licensee did not ensure that the plan of care included an order by a physician or registered nurse in the extended class for the restraining of a resident by a physical device.

An identified resident was observed to be seated in a broda chair, with a 4 point safety belt. The plan of care for this resident indicates that the 4 point safety belt is used to maintain the resident's safety in the chair due to a risk of falls. The most recent quarterly medication review, which effectively discontinues all previous orders, indicates an order for the use of the broda chair. The quarterly medication review does not indicate the use of the 4 point safety belt as a restraint. It was determined that the resident does not have a current physician order for the use of the 4 point safety belt as a restraint.

In addition, the resident's health care record was reviewed on April 23, 2014 and it could not be demonstrated that a documented consent to the use of the 4 point safety belt, as a restraint, had been obtained from the resident's substitute decision maker. [s. 31. (2) 4.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During this inspection a minimum of 40 resident health records were reviewed that included each nursing unit in the home. The review demonstrated that resident heights were measured upon admission, however, resident heights were not measured annually thereafter.

On April 17, 2014, Inspector #148 spoke with two Registered Nursing staff members, #S100 and #S102, who reported that resident heights are measured on admission. Both staff members indicated that at the present time the home does not measure resident heights annually. This was confirmed by the home's DOC. [s. 68. (2) (e) (ii)]

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

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.85 (1), whereby the licensee did not ensure that at least once in every year, a survey is taken of the resident's and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Inspector #148 spoke with the home's Resident Council President, who reported that it was his/her belief that only residents who were able to speak for themselves were surveyed during the 2014 satisfaction survey. A document, provided by the Council President, titled Quality Improvement Plan, dated July 2013, indicated that the 2013 survey was completed with family members of residents with a CPS (Cognitive Performance Scale) of more than 3 and that the 2014 survey would be completed with residents with a CPS of 3 or less. The Council President was concerned that not all residents and family members were being provided a satisfaction survey each year.

Inspector #148 spoke with the home's DOC who confirmed that the home implements their survey each year but does not survey all resident's and their families each year. The DOC described the current satisfaction survey model to include alternating each year between residents with a CPS of 3 or less and families of those residents with a CPS of more than 3. [s. 85. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 241. (7) (f) in that the licensee did not ensure that quarterly itemized statements are provided to the resident, or to a person acting on behalf of a resident respecting money held by the licensee in trust for the resident that include: deposits, withdrawals, and the balance of the resident's funds as of the date of the statement.

On April 22, 2014, the power of attorney for finances (POA), for an identified resident, reported to Inspector #550 that the home hold funds for this resident within the trust account. The POA further reported that to date, no statement from the home, related to this trust account, has been provided.

The Assistant Administration, reported to Inspector #550 that an itemized statement of funds held for a resident in trust, is provided only upon the request of the resident or substitute decision maker. The home does not provide a itemized written statement on a quarterly basis to all residents or the person acting on their behalf.

A review of the licensee's policy titled 'Resident Trust Accounts" section 5. (f). indicates: 'provide to the resident , or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement'. [s. 241. (7) (f)]

Issued on this 29th day of April, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Amanda Nixon RD LTCH Inspector