Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARGOT BURNS-PROUTY (106), DIANA STENLUND (163), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2013_211106_0006
Log No. / Registre no:	S-000003-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 6, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	ROSEVIEW MANOR 99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOANNE LENT

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all staff participate in the implementation of the infection prevention and control program, specifically, hand hygiene during medication administration and meal services.

Grounds / Motifs :

1. On April 16, 2013, the keyboard on a resident home area medication cart was noted to have a light covering of a white powdery substance. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. (106)

2. On April 12, 2013, staff member #S-102 was observed during lunch service to clear the resident dining tables of soiled soup bowls and then proceed to the servery counter to get main plates for residents. No hand washing or sanitizing by this staff member was observed. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

A servery splash guard was noted to be heavily soiled with dried debris/liquids and the servery counter top had a piece of black duct tape over a piece of missing counter top. A medication cart was noted on April 12, 2013, to have obvious debris such as, food crumbs present in all corners of medication drawers and the surface of the cart was soiled. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. (196)

3. On April 16, 2013, staff member #S-106 was observed removing medication from a blister pack into their hand and then placing the medication into a med

cup for two different residents. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. (106)

4. On April 12, 2013, inspector observed staff member #S-105, open medication packages, pour the pills into their hand and then place the medication into a medication cup. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. (106)

5. Inspector observed during meal service on two different resident home areas, that staff removed dirty dishes from resident tables and then continued to serve residents their meals without following hand hygiene practices in between. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On a resident home area, inspector observed an RPN place medications into the palm of their hand prior to placing the medications into a pouch for crushing. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2013

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to residents #100 and #692 as specified in the plan.

Grounds / Motifs :

1. On April 9, 2013 at 1635hrs, the inspector observed resident #100 in the common dining room of a resident home area, eating whole grapes from a fruit basket located on the counter of the servery. The health care record was reviewed and the resident was to receive a pureed diet. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (196)

2. Inspector observed over the course of the inspection resident #692 who is documented to be at high risk for falls. The resident's plan of care requires a chair alarm to be in place when sitting in their wheelchair. The inspector observed on two occasions during the inspection that the chair alarm was not in place when the resident was in their wheelchair. The licensee has not ensured the care set out in the plan of care is provided to the resident as specified in the plan. (163)

3. Inspector reviewed the plan of care for resident #692, it indicated that they are incontinent and are required to be toileted every 2hrs and prn. The inspector observed that between breakfast and lunch on April 17, 2013 this resident was not toileted every 2 hours as per the care set out in the plan of care. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan. (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of June, 2013

Signature of Inspector / Signature de l'inspecteur : 

Name of Inspector / Nom de l'inspecteur : MARGOT BURNS-PROUTY

Service Area Office / Bureau régional de services : Sudbury Service Area Office

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2013	2013_211106_0006	S-000003-13	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

ROSEVIEW MANOR
99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2

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

MARGOT BURNS-PROUTY (106), DIANA STENLUND (163), LAUREN TENHUNEN (196)

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 8, 9, 10, 11, 12, 15, 16, 17, 18, 2013

The following logs were reviewed as part of this Resident Quality Inspection: S-000003-13, S-000097-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Business Manager, Dietary Aides, the Food Service Supervisor, Environmental Services Manager, Environmental Services staff, Houskeepers, Activation staff, Resident Council President, Family Council Member, Residents and Families

During the course of the inspection, the inspector(s) conducted a daily walk through of resident care areas, observed staff to resident interactions, observed meal service, reviewed residents' health care records, reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Inspector observed during meal service on two different resident home areas, that staff removed dirty dishes from resident tables and then continued to serve residents their meals without following hand hygiene practices in between. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On resident home area, inspector observed an RPN place medications into the palm of their hand prior to placing the medications into a pouch for crushing. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. On April 12, 2013, inspector observed staff member #S-105, open medication packages, pour the pills into their hand and then place the medication into a medication cup. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

3. On April 16, 2013, staff member #S-106 was observed removing medication from a blister pack into their hand and then placing the medication into a med cup for two different residents. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

4. On April 12, 2013, staff member #S-102 was observed during lunch service to clear the resident dining tables of soiled soup bowls and then proceed to the servery counter to get main plates for residents. No hand washing or sanitizing by this staff member was observed. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

A servery splash guard was noted to be heavily soiled with dried debris/liquids and the servery counter top had a piece of black duct tape over a piece of missing counter top. A medication cart was noted on April 12, 2013, to have obvious debris such as, food crumbs present in all corners of medication drawers and the surface of the cart was soiled. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

5. On April 16, 2013, the keyboard on a medication cart was noted to have a light covering of a white powdery substance. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

[s. 229. (4)]

6. Two residents out of a sample of five, did not have record of screening for tuberculosis within 14 days of admission to the home. A review of the health care records did not include record of screening 90 days prior to admission to the home. The licensee failed to ensure that the following immunization and screening measures are in place: Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 1.]

7. Interview with staff member #S-111 on April 17, 2013 at 1005hrs. It was reported that residents are not offered immunization for pneumococcus, tetanus/diphtheria on admission to the home and was not aware this was required. The licensee failed to ensure that the following immunization and screening measures are in place: Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 following immunization and screening measures are in place: each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee and residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The most recent continence assessment for resident #751 indicates the resident is continent, the most recent RAI MDS assessment indicates that the resident is incontinent for both bladder and bowels. On April 17, 2013, staff member #S-103, told inspector that the resident #751 was continent, but required assistance to toilet and on April 18, 2013 staff member #S-104 reported that the resident was incontinent. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other. [s. 6. (4) (a)]

2. The most recent RAI MDS assessment indicates that resident #757 requires the assistance of 2 persons to transfer, the plan of care and Kardex, also indicates the resident is a 2 person transfer. A physiotherapy assessment progress note dated March 12, 2013 indicates the resident's transfer status is one person assist. Two staff members working on the resident's home area were interviewed and they both reported that the resident transferred with the assistance of one person. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

3. Inspector reviewed the plan of care for resident #692, it indicated that they are incontinent and are required to be toileted every 2hrs and prn. The inspector observed that between breakfast and lunch on April 17, 2013 this resident was not toileted every 2 hours as per the care set out in the plan of care. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

4. Inspector observed over the course of the inspection resident #692 on a resident home unit who is documented to be at high risk for falls. The resident's plan of care requires a chair alarm to be in place when sitting in their wheelchair. The inspector observed on two occasions during the inspection that the chair alarm was not in place when the resident was in their wheelchair. The licensee has not ensured the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

5. On April 9, 2013 at 1635hrs, the inspector observed resident #100 in the common dining room of a resident home area, eating whole grapes from a fruit basket located on the counter of the servery. The health care record was reviewed and the resident was to receive a pureed diet. The licensee failed to ensure that the care set out in the

plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

6. Resident #692 had a fall and suffered a fracture. The resident was sent to hospital and underwent surgery. Inspector noted from the health care record that the resident's care needs changed upon readmission to the home (transferring requirements, assistance, monitoring, medication and physiotherapy needs). Review of the records indicated that the care plan document was not revised until 6 weeks after the resident returned from hospital. The licensee failed to ensure that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

7. Resident #796 had a documented fall in February and again in March, 2013. The health care record was reviewed, specifically the care plan, and despite these two falls the only revision to the plan was a change in physiotherapy treatment. There were no different approaches included in the plan of care to address the resident"s falls. The licensee failed to ensure that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 plans of care for resident #692 and #796 are reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary and that staff and others involved in the different aspects of care collaborate with each other in the assessment of residents #751 and #757 so that their assessments are integrated, consistent and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Policy #ICM-A-110 with subject "Screening for Tuberculosis" dated September 2001 was reviewed for information regarding TB skin testing for resident admissions. The policy reads "Residents admitted to the home will be screened for tuberculosis (TB) within fourteen (14) days of admission unless the results of a previous two-step Manoux test within the last year are available." Two of five residents that were reviewed did not have documentation of screening for TB, in their health care records, within fourteen days of admission to the home.

Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, specifically regarding, residents admitted to the home will be screened for tuberculosis (TB) within fourteen (14) days of admission unless the results of a previous two-step Manoux test within the last year are available, to be implemented voluntarily.

WN #4: 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. On April 17, 2013, Resident #751 was noted to have a build up of dried food and debris on their wheelchair seat belt. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

2. The inspector observed in two resident home area dining rooms prior to meal service that the splash guards surrounding the steam tables had food debris splattered on them. The licensee has not ensured that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

3. Inspector observed residents on two resident home areas. It was noted that residents #692, #726 and #797 had wheelchairs that were not kept clean (seat cushions and/or seatbelts). The licensee has not ensured that, the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

4. On April 12, 2013, the plastic bowls found on the resident dining tables in a resident home area dining room, were soiled with food crumbs and dried food stuff and the splash guard surrounding the steam table was heavily soiled with dried food debris. The licensee failed to ensure that, the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

5. On April 12, 2013, Inspector #196 observed black duct tape on the counter top surface of the servery in a resident home area. The tape was covering an area of the counter top that had been chipped and in a poor state of repair. The licensee failed to ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [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 ensured that, the home, furnishings and equipment are kept clean and sanitary, specifically regarding the splash guards surrounding steam tables, bowls left on dining room tables and residents #692, #726, #797, #735 wheelchairs and/or seatbelts, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. On April 9, 2013, resident #746 was observed to have food debris on their natural teeth. On April 16, 2013 at 1010hrs, the resident was observed and had plaque build up on the natural teeth and the upper full denture had food debris present and partial denture, had food debris present. The most recent care plan was reviewed and noted the resident as being totally dependent and requires staff assistance with mouth care. The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth. [s. 34. (1) (b)]

2. Inspector observed resident #692 who has a plan of care indicating that they require assistance with their mouth care. Inspector noted on two occasions that this resident had clearly visible food residue collected around teeth and gums, and that their teeth were heavily stained. The licensee has not ensured that residents receive oral care to maintain the integrity of the oral tissue that includes physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth. [s. 34. (1) (b)]

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 residents receive oral care to maintain the integrity of the oral tissue that includes physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth, specifically Resident # 746 and #692, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The most recent continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence for resident #751, was completed September 2009. This assessment indicates that the resident was continent. On April 18, 2013, staff member #S-104, told inspector 106 that the resident was incontinent but will still ask to be toileted. No continence assessment was found that was completed when the resident's condition changed and they became incontinent. The licensee failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. The inspector reviewed the health care record and interviewed staff about resident #748 with regards to their continence. The inspector noted that this resident was continent of both bladder and bowel upon admission to the home (2009) and is currently documented to be frequently incontinent of both bladder and bowel. A continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence was not completed on this resident since the change in their continence status. The licensee has not ensured that, each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

3. Inspector reviewed the health care record for resident #692 with respect to their continence. The inspector noted that upon admission in 2002 the resident was assessed as continent, however current documentation indicates that this resident is incontinent of both bladder and bowel. The inspector was unable to locate that a clinically appropriate incontinence assessment was completed on resident #692 since becoming incontinent. The licensee has not ensured that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that

is specifically designed for assessment of incontinence. [s. 51. (2) (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 who is incontinent and specifically residents #692, #748 and #751 receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dinlng and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. On April 10, 2013 at 0925hrs, the inspector observed the common dining room in a resident home area, and noted there were six residents seated at dining tables and there were no staff members in attendance. During the time period of 0925hrs through to 0938hrs, residents #008 and #009 were observed eating porridge and toast and orange slices. Concern was brought forward to staff member #S-110, who then confirmed that "someone should've been in the dining room supervising the residents" and that it is the home's policy to have staff in the dining room while residents are eating. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. [s. 73. (1) 4.]

2. On April 8, 2013, a resident home area dining room was observed over the lunch service. Resident #001 was observed attempting to eat long spaghetti noodles out of a bowl with a spoon. Resident #001 expressed frustration when the noodles would not stay on the spoon, and started to eat them with the fingers of one hand. Staff were not observed to provide assistance to the resident and within a short time, the resident was observed to push the bowl away and stop eating. The dietary census list was reviewed and noted "assist as needed" for resident #001. Resident #001 was not provided with personal assistance to eat comfortably and independently. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

3. In two resident home area dining rooms at meal service, inspector observed improper techniques being used to assist residents with eating (standing while assisting the resident). The licensee has not ensured that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance. [s. 73. (1) 10.]

4. On April 12, 2013 at 1230hrs and again at 1240hrs, staff member #S-102 was observed to feed resident #101 while standing. The licensee has not ensured that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance. [s. 73. (1) 10.]

5. The inspector noted in a resident home area that residents #692 and #748 had

plans of care that stated they require assistance with eating. Inspector observed that these two residents had to wait approximately ten minutes after their meal was placed in front of them before they received assistance with their meal. The licensee has not ensured that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. [s. 73. (2) (b)]

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 has a dining and snack service that includes, at a minimum, the following elements: monitoring of all residents during meals, providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance, Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat, and that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On April 9, 10, 2013, a strong urine smell was noted in the hallway out side a resident room and the odour was found to be stronger in the resident's washroom. On April 15,16 and 17, 2013 a lingering urine odour was noted in a resident's washroom. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures are developed and implemented for,(d) addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

2. On April 9, 2013, a complaint was received by the inspector regarding a persistent urine odour in a resident room. During a walk through of a resident home area corridor, on April 11, 2013 at 1655hrs, a profound odour of urine was encountered while passing by a resident's room. The same lingering urine odour was present on April 12, 2013 at 0935hrs, in the corridor and in the resident's room.
An interview was conducted with staff member #S-107 on April 12, 2013 at 0940hrs, regarding the urine odour. It was reported that a requisition was put into the maintenance the previous week. A requisition from March 6, 2013 noted the carpet needs to be cleaned and notes the carpet was then cleaned on Mar. 7, 2013. Staff member #S-107 indicated this was not the first time the carpet required to be cleaned multiple times in a short period of time. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures are developed and implemented for,(d) addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

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 procedures are developed and implemented for, addressing incidents of lingering offensive odours, specifically regarding odours in rooms 3213 and 2112, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. During a review of the medication cart on a resident home area on April 12, 2013, the hearing aids of resident #002 were observed to be stored in the top drawer. The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

2. Staff members #S-106 and #S-108, both stated that regularly ordered Ativan is stored in the compliance roll package with the other medications and not stored in the double locked area of the medication cart where the other controlled substances are kept including the PRN Ativan. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

3. On April 12, 2013, Inspector #196 reviewed the medication cart and the emergency drug box on a resident home area. The controlled substance Ativan, was noted to be in the compliance roll package for a resident in the medication cart and the emergency drug box was noted to contain ten tablets of Ativan 1mg in compliance roll packages. Neither the compliance roll packages, nor the emergency drug box is double-locked as is required. According to staff member #S-107, the home is going to start having the Ativan dispensed into cards and then it will be doubled-locked in the narcotic lock box. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

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 controlled substances, specifically Ativan are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. On April 12, 2013, staff member #S-105 was observed to leave their medication cart unlocked walk down the hall out of sight of the cart and return 3 minutes later. The licensee failed to ensure that all areas where drugs are stored are kept locked at all times when not in use. [s. 130. 1.]

2. On April 18, 2013, an environmental services staff member and not a member of the registered staff, opened the government stock medication room with their own key. The staff member told the inspector that they are required to have access to this room when they deliver boxes that are stored in this room. The licensee failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator. [s. 130. 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 all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. On April 12, 2013, resident #783 was observed to have two containers of prescription topical creams at the bedside. Staff member #S-109 confirmed to the inspector that the treatment cream had been applied to the resident's left arm on April 12, 2013. The health care record was reviewed and did not contain a prescription for this treatment cream. An interview was conducted with staff member #S-107 on April 12, 2013 and it was reported that this cream should not be used as there isn't an order for it to be used. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

2. An interview was conducted with staff member #S-107 on April 12, 2013 and it was reported that resident #007 has been ordered prescription treatment creams and the creams are applied by the resident and they are kept at the bedside. The health care record was reviewed by the inspector and did not contain an order for the self application of the prescription treatment creams, nor was there an order to keep the medications at the resident's bedside. The licensee failed to ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except, (a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and (b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. [s. 131. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to resident # 783 in the home unless the drug has been prescribed for the resident and that resident #007 is not permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except, (a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and (b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On April 18, 2013, a resident was noted to have very strong halitosis, was unshaven with stubble that was approximately 3 mm long. The licensee failed to ensure that this resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [s. 3. (1) 4.]

2. On April 17, 2013, staff member #S-108 was observed to administer insulin to resident # 781, in the doorway of their room, the resident's abdomen was exposed when their shirt was lifted when the staff member administered the medication and the resident was facing towards the hall. The licensee failed to ensure that the resident's right to be afforded privacy in treatment was fully respected and promoted. [s. 3. (1) 8.]

3. On April 12, 2013 at 0927 hrs, staff member #S-105 was observed to administer insulin to resident # 781 at the dining room table, while other residents were seated at the table. The licensee failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted. [s. 3. (1) 8.]

4. On April 12, 2013, Inspector #196 observed the medication administration on a resident home area at 1145hrs by staff member #S-107. Resident #005 and #006 were observed to receive their insulin injections while in the hallway outside the common dining room, in view of other residents, visitors and staff. The licensee failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted. [s. 3. (1) 8.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. On April 12, 2013, the contents of the medication cart on resident home area were reviewed by the inspector. Three residents were noted to have medication in the cart that was provided by family, as confirmed by staff member # S-107. Specifically, the cart contained a bottle of "Buckley's cough syrup" with resident #858's name hand written on it, a bottle of Vitamin C with resident #703's name, and a bottle of Multivitamins with resident #004's name on it. These medications had not been provided by the home's pharmacy service provider nor the Government of Ontario as is required. The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. [s. 122. (1)]

Issued on this 10th day of June, 2013

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