Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2021	2021_891649_0018	000546-21, 004055-21, 005947-21, 007936-21, 009010-21, 009273-21, 009354-21, 010460-21, 012397-21, 013552-21, 014746-21	Complaint

Licensee/Titulaire de permis

Villa Colombo Homes for the Aged Inc.
40 Playfair Avenue Toronto ON M6B 2P9

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

Villa Colombo Homes for the Aged
40 Playfair Avenue Toronto ON M6B 2P9

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

JULIEANN HING (649), JOY IERACI (665), ORALDEEN BROWN (698)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 26, 27, 30, 31, September 1, 2, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, October 1, 5, off-site September 3, 7, 8, October 8, and 12, 2021.

The following complaint intakes were completed during this complaint inspection:
Log #000546-21 related to duty to protect and Family Council,
Log #004055-21 related to skin and wound care,
Log #005947-21 related to plan of care,
Logs #007936-21, #009354-21, #010460-21, #012397-21 related to prevention of abuse and neglect,
Log #009010-21 related to transferring and positioning,
Log #009273-21 related to duty to protect,
Log #013552-21 related to infection prevention and control practices,
Log #014746-21 related to administration of drugs.

A Written Notification (WN) and a Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c.8, s. 5 and a WN related to s. 6. (9) 1 were identified in Critical Incident System (CIS) report #2021_891649_0017 which was conducted concurrently with this inspection and will be issued in this report.

A WN related to LTCHA, 2007, c.8, s. 6. (4) (b) was identified in Complaint report #2021_846665_0003 which was conducted concurrently with this inspection and will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Medical Director (MD), Executive Director (ED), Assistant Executive Director (AED), Director Resident Services (DRS), Directors, Nursing Unit (DNU), Infection Prevention and Control (IPAC) Lead & Clinical Educator, Nurse Managers (NMs), Physiotherapist (PT), Registered Nurses (RNs), Registered Dietitian (RD), Manager of Housekeeping and Laundry, Programs Manager (PM), Public Health Nurse, Social Worker (SW), Behavioural Supports Ontario (BSO) Nurse, Registered Practical Nurses (RPNs), Volunteer Supervisor, Interim-Executive Assistant (I-EA), Recreation Aides (RAs) Personal Support Workers (PSWs), Housekeeper Aides (HKAs), Dietary Aide (DA), PSW Student, residents, and Family Members.

During the course of the inspection the inspectors reviewed residents' health records, staffing schedules, investigation notes, conducted observations related to the home's care processes, resident to resident interactions, and reviewed any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 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. The licensee has failed to ensure that the home's medication management policy was complied with.

A complaint was reported to the Ministry of Long-Term Care (MLTC), related to an allegation that a medication was found in a resident's mouth thus placing the resident at risk of choking.

O. Reg. 79/10, s. 114 (1) directs the licensee to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Specifically, staff did not comply with the home's safe medication management policy #RC-16-01-07 last updated December 2020, that directed staff to ensure that medication was ingested after it was administered to a resident. A family member who was visiting with the resident at the time observed medication in the resident's mouth and brought it to a staff's attention.

A review of the resident's electronic-medication administration record (e-MAR) indicated that a controlled substance was administered to the resident by a Registered Nurse (RN).

Personal Support Worker (PSW) told the inspector that they became aware of the tablet in the resident's mouth from a family member visiting with the resident. According to the PSW they were shown the tablet in the resident's mouth by the family member and provided the resident with water from a teaspoon and saw it dissolved. The PSW reported what had occurred to the RN.

The RN acknowledged that they were informed by a PSW of the above incident but could not recall their name. They told the inspector that they had administered a controlled substance to the resident earlier in the day same time that the resident's family member was assisting them with their meal. They explained that the medication was administered whole to the resident as they were able to swallow, and they had not noticed that the resident had not swallowed it. The RN confirmed that safe medication practices were not followed when the medication was administered to the resident. They further explained that they had not reported this incident as they had not seen the medication in the resident's mouth, and only became aware of it from the PSW. They denied that their action placed the resident at risk of choking.

This concern was brought to the Director of Nursing Unit (DNU)'s attention who acknowledged that safe medication practices were not followed, and that it was the registered staff responsibility to ensure that the resident had swallowed their medication.

Sources: review of resident's clinical records, e-MAR, interviews with a PSW, RN, and other staff. [s. 8. (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 the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PSW complied with the home's written policy that promotes zero tolerance of abuse and neglect of residents, related to reporting an allegation of abuse towards a resident.

The home's management team was made aware by a PSW of an allegation of sexual abuse towards a resident by another PSW. A PSW informed the management team that an allegation of sexual abuse had occurred.

The home's policy titled, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, indicated that for any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect to report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

The Nurse Manager (NM) verified that they were approached by a PSW, but was busy at the time and the PSW did not say it was about an allegation of abuse.

The NM and Director of Nursing Care (DNC) confirmed that the PSW did not comply with the home's policy as the allegation of sexual abuse was not reported immediately, until 12 days after the alleged incident.

Sources: Zero Tolerance of Resident Abuse and Neglect: Response and Reporting Policy #RC-02-01-02, investigation notes, critical incident report (CIS), and interviews with PSW, NM, and DNC. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident or the resident's substitute decision-maker was notified when the resident required new personal belongings.

A complaint was reported to the MLTC related to a resident who was taken outdoors for a visit with family members inappropriately dressed. According to the complainant they were not notified by the home that the resident required more clothing.

Record review of the resident's clinical records did not indicate any documentation of communication between the home's staff and the resident's substitute decision-maker (SDM) requesting clothing for the resident until after the above mentioned visit.

The PSW acknowledged that on the day of resident's visit with family member there were no other clothing available in the resident's closet. They confirmed that the resident had an ongoing shortage of clothing. They were unable to say how long the resident had the shortage of clothing, since they had not worked with the resident often.

Another PSW confirmed that the resident required more clothing. According to the PSW, the resident required more clothing for several months and stated that they had reported to the nurse but could not recall who.

This concern was brought to the DNU's attention who acknowledged that staff should have contacted the resident's family and requested more clothing for the resident.

Sources: review of resident's clinical records, interviews with PSWs, and other staff. [s. 38. (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 a resident or the resident's substitute decision-maker is notified when the resident requires new personal belongings, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

A complaint was reported to the MLTC related to a concern that an antibiotic medication was found in the resident's mouth.

Record review indicated that the physician ordered an antibiotic for the resident one tablet once daily for 10 days. According to the e-MAR this order was processed as an immediate (STAT) order and the medication was administered to the resident. A second dose of the same antibiotic was given to the resident at the scheduled time, resulting in the resident receiving two doses of the medication in one day instead of the one dose that was ordered by the physician.

The RN acknowledged receipt of the order from the physician for the antibiotic once daily for an infection. They recalled processing the order as a STAT order and administered the medication to the resident on the same day. They confirmed upon review of the e-MAR that the antibiotic was administered to the resident again at a later time, thus confirming that the physician's order was not followed.

The Registered Practical Nurse (RPN) acknowledged that they had administered the antibiotic to the resident at the scheduled time. After reviewing the e-MAR they realized that there was a STAT order for the same medication already given to the resident earlier that day. They confirmed that the physician's order was not followed.

Sources: review of resident's clinical records, physician orders, e-MAR, interviews with RN, and RPN. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was reported to the MLTC related to an allegation that personal protective equipment (PPE) practices were not being followed by the home's staff.

A review of the home's zoom video call, attended by family council members and the home's staff indicated that two staff members were observed not wearing their mask and were not physically distancing.

According to Coronavirus (COVID-19) guidance document for long-term care homes in Ontario updated on May 25, 2021, under the section titled infection prevention and control guidance, it indicated that during breaks staff must remain two metres away from others at all times and be physically distanced before removing their medical mask for eating and drinking.

One of the staff advised that they were having something to drink during the zoom meeting and the second staff advised that they were having their lunch.

Non-compliance was identified since two staff were observed not physically distancing during the zoom call, when they had removed their mask to eat and drink.

Sources: review of zoom video recording of family council meeting, COVID-19 guidance document for long-term care homes in Ontario, and interviews with staff.

2. The following observations were made by Inspectors #649 and #707428 related to the home's infection prevention and control (IPAC) practices.

-On Thursday August 26, 2021, Inspectors #649 and #707428 arrived at the home and were not actively screened. Upon entry the inspectors were asked to change their mask and to complete a paper screening tool titled Visitor active screening log for visits.

-On Friday August 27, 2021, Inspectors #649 and #707428 arrived at the home at separate times, and were not actively screened. The inspectors were asked to complete a paper screening tool titled Visitor active screening log for visits.

The Front Desk Security staff explained that their role was to ensure that anyone who entered the home changed their mask and sign in and out. They confirmed that visitors were asked to complete the home's screening tool titled Visitor active screening log for visits, and therefore were not being actively screened by the home's staff.

The above concern was brought to Director Resident Services (DRS)'s attention, since the home’s Infection Prevention and Control (IPAC) Lead and Clinical Educator was unavailable.

The above mentioned observations were later brought to the home’s IPAC Lead and Clinical Educator. They confirmed that when a visitor enters the home they were to be actively screened by the home’s staff.

Sources: Inspectors #649 and #707428’s observations on August 26 and 27, 2021, interviews with Front Desk Security staff and home’s IPAC Lead and Clinical Educator, and other staff. [s. 229. (4)]

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 staff participate in the implementation of the program, to be implemented voluntarily.

WN #6: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

A resident stated that staff were sometimes rough while repositioning them when in bed, and were rushing out of the room after providing care.

The NM acknowledged that the resident was cognitively intact and had reported their concerns about staff being rough during turning and repositioning. The NM indicated that the resident required several staff members assistance to be repositioned.

Sources: resident's electronic clinical record, interview with resident, NM and others.

The following is further evidence to support the order issued on June 22, 2021, during inspection 2021_644535_0005 with a compliance due date of October 15, 2021.

Review of the home's Compliance History revealed a history of non-compliance related to the LTCHA, 2007, s. 3. (1) 1. An order was issued under s. 3. (1) 1. during inspection report #2021_644535_0005 dated June 22, 2021, with a compliance due date of October 15, 2021. A written notice (WN) has been issued under s. 3. (1) 1. as additional evidence for the existing order. [s. 3. (1) 1.]

2. The licensee has failed to fully respect and promote resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A complaint was reported to the MLTC related to a resident being taken to the garden inappropriately dressed.

Record review indicated that the resident was taken to the garden for a visit. Subsequent documentation indicated that the resident was inappropriately dressed during the above mentioned visit.

In preparation for a resident’s outdoor garden visit, the PSW told the inspector that they were informed by the nurse which residents were scheduled for a garden visit and at what time. The PSW was responsible for ensuring that the resident was appropriately dressed according to the weather conditions by an identified time.

The PSW remembered taking the resident downstairs for a visit on the above mentioned date. They confirmed that the resident was inappropriately dressed during the garden visit.

This concern was brought to the DNU’s attention who acknowledged that the resident was not properly clothed during the above mentioned visit.

Sources: review of resident’s clinical records, interviews with PSW and other staff. [s. 3. (1) 4.]

WN #7: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident’s plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A complaint was reported to the MLTC related to an allegation of neglect that a resident was not taken outside for fresh air.

Record review indicated that the resident was taken outdoors after the home’s Coronavirus (COVID-19) exposure ceased at the end of May 2021.

Record review indicated that an activities assessment was completed for the resident after their admission to the home. According to this assessment it indicated that the resident enjoyed the outdoors and used to grow their own vegetable garden. The resident's assessed interest that they enjoyed the outdoors and used to grow their own vegetable garden was not included in their care plan.

Programs Manager (PM) confirmed that the assessment indicated that the resident enjoyed the outdoors. They explained that the resident only wanted to go outside to plant

vegetables and had refused many other offers to go outside. The resident's refusals were not documented. PM confirmed that the resident's care plan should have been updated with the resident's assessed needs and preferences according to their activities assessment.

Sources: review of resident's clinical records, interview with PM and other staff. [s. 6. (2)]

2. The licensee has failed to ensure that staff involved in the different aspects of care collaborated with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A resident had been assessed as high risk for falls and had a history of falls. The resident sustained a fall and several days later the RPN documented that a specific device will be in place when the resident was in bed.

Observation conducted by Inspector #665 on an identified date, revealed the resident asleep in bed without a specific device in place. The PSW confirmed the resident did not have the specific device.

Interview with the RPN, revealed they were not aware that a specific device was a new intervention for the resident. The RPN indicated that the specific device was a falls intervention. The RPN confirmed they did not implement the specific device after the resident's fall, as they could not find a working device and did not inform their Nurse Manager.

Another RPN confirmed that they were aware of the intervention but could not find a working device and did not inform the charge nurse. The RPNs and NM all acknowledged there were no collaboration amongst the registered staff in the implementation of the specific device in the resident's plan of care.

Sources: The resident's progress notes, assessments, care plan, interviews with RPNs, NM, and others. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care were documented for three residents.

A complaint was reported to the MLTC related to bathing/showers not provided to a resident.

Record review of the resident's shower records in point of care (POC) indicated no documentation of the provision of shower/bath on four dates. On these dates POC was left blank or documented not applicable. Progress notes were reviewed for the above mentioned dates and there was no documentation related to the resident bath/showers.

The PSWs who worked with the resident in April 2021, could not recall if they had provided a shower/bath to the resident.

The PSWs who worked with the resident in June 2021, could not recall if they had provided a shower/bath to the resident.

DNU told the inspector that staff should be documenting right after completion of the task. They went on to say if the resident had refused their shower/bath, the charge nurse should have been made aware and documented in the progress notes.

Sources: review of resident's clinical records, interviews with PSWs, and other staff. [s. 6. (9) 1.]

4. Two residents had diagnosis of Type 2 diabetes mellitus with poor control. Both residents had physician orders that required blood glucose (BG) monitoring four times per day.

The first resident's e-MAR did not have documentation of the BG levels on three instances.

Another resident's e-MAR had an incorrect BG level.

Interviews with two RPNs verified that they had checked the BG levels but had not documented the levels as per the plan of care.

Sources: two resident's e-MAR, Physician Orders, clinical notes, and interviews with two RPNs. [s. 6. (9) 1.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Family Council had advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

A complaint was reported to the MLTC related to no written response provided by the home to a recommendation made by Family Council.

A review of Family Council meeting minutes dated September 1 and November 5, 2020, documented as follows:
-September 1, 2020: suggestions to improve air quality included increase in ventilation, limit recirculated air, and use of portable air filters.
-November 5, 2020: suggested air purifiers for areas with VOCs (volatile organic compounds) and where ventilation was poor.

The Assistant Executive Director (AED) confirmed that a written response was not provided to Family Council within 10 days for the above mentioned recommendations. They told the inspector that during the Coronavirus pandemic the process of responding to Family Council within 10 days was not maintained.

Sources: Review of Family Council meeting minutes dated September 1 and November 5, 2020, and interview with the AED, and other staff. [s. 60. (2)]

Issued on this 9th day of November, 2021

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

Original report signed by the inspector.