Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 23, 2017	2017_557575_0007	001776-17	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St. NORTH BAY ON P1B 6J4

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

CASSELLHOLME
400 OLIVE STREET NORTH BAY ON P1B 6J4

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

LINDSAY DYRDA (575), LISA MOORE (613), SARAH CHARETTE (612), SYLVIE BYRNES (627)

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): February 27 - March 3, 2017 and March 6-10, 2017.

The following additional intakes were inspected during this Resident Quality Inspection:

Follow up related to four compliance orders (COs) issued during inspection

2016_332575_0016 and 2016_336620_0019. Specifically:

-CO #001 issued during inspection 2016_336620_0019 related to care being provided as specified in the plan of care;

-CO #002 issued during inspection 2016_336620_0019 related to staff following manufacturers' instructions regarding bed systems;

-CO #001 issued during inspection 2016_332575_0016 related to doors in the home; and

-CO #002 issued during inspection 2016_332575_0016 related to the duty to protect residents from abuse and neglect.

-Seven Critical Incidents (CIs) the home submitted to the Director regarding alleged resident to resident abuse.

-Four CIs the home submitted to the Director regarding alleged staff to resident abuse.

-Two CIs the home submitted to the Director regarding resident falls.

-One complaint submitted to the Director regarding alleged staff to resident abuse.

-One complaint submitted to the Director regarding allegations of unsafe medication administration.

-One complaint submitted to the Director regarding alleged inappropriate behaviour of two staff.

-One complaint submitted to the Director regarding alleged resident to resident abuse, activities in the home, and the care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Vice President of Clinical Services, Manager of Clinical Services, Manager of Infection Control, Director of Operations, Manager of Housekeeping and Laundry, Dietary Manager, Manager of Maintenance, Manager of Activities/Day Program, Resident Assessment Instrument Coordinator, Resident Services Coordinator, Unit

Support Assistant, Behavioural Supports Ontario staff, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping staff, Maintenance staff, Food Service staff, family members, and residents.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Trust Accounts

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #002	2016_332575_0016	575
O.Reg 79/10 s. 23.	CO #002	2016_336620_0019	612
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_336620_0019	613
O.Reg 79/10 s. 9. (1)	CO #001	2016_332575_0016	627

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 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 has failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.

On February 28, 2017, Inspector #575 noted a call bell on the first floor did not have a button to press. Inspector #612 noted a different call bell on the first floor did not activate when pressed by the Inspector.

On March 6, 2017, Inspector #575 observed both call bells and noted that the call bell in one room did activate when pressed by the Inspector, however, the call bell in the other room did not have a button to press.

During an interview with RN #108, they confirmed to the Inspector that the cord in resident #003's room was for a certain device; the RN stated that staff should have notified maintenance when the resident discontinued using the certain device in order to replace the device with a press button cord.

Inspector #575 reviewed resident #003's plan of care and noted a progress note which indicated that the certain device was discontinued in October 2016.

During an interview with Manager #120, they confirmed that staff were to notify maintenance when call bells were noted to need replacing or were not working. Manager #120 confirmed that they received notification regarding the call bell identified by the Inspector, and they had replaced the call bell cord in resident #003's room. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During an interview with Manager #120, they indicated to Inspector #575 that there was no resident-staff communication and response system available in the Chapel. They confirmed that the Chapel was open at all times, and was accessible by residents.

During observations on March 7, 2017, Inspector #575 noted no communication and response system in the Chapel. In addition, in a specific home area, there was no communication and response system located in the main lounge area or dining area. A panic button was noted in the dining area, however, it was not easily visible and was not for resident and visitor use. [s. 17. (1) (e)]

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 ensuring that the resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times and is available in every area accessible by residents, 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 written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in July 2016. The CI report described an allegation of staff to resident abuse that occurred the previous day. The CI report indicated that Registered Practical Nurse (RPN) #116 overheard an incident between Personal Support Worker (PSW) #115 and resident #027. The CI report indicated that RPN #116 did not report the incident to a supervisor until the following day.

The home's policy titled "Abuse, Neglect and Retaliation Prevention" last revised February 2017, indicated that any person must immediately report to a supervisor all suspected, alleged or witnessed incidents of resident abuse or neglect, regardless of their personal judgement that it may not be valid.

During an interview with Manager #110, they stated that RPN #116 should have brought forward the allegation immediately. [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 ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

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

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in July 2016. The CI report described an allegation of resident to resident abuse that occurred the previous day. According to the CI report, resident #025 pushed resident #026 which caused resident #026 to fall.

Inspector #575 reviewed the home's investigation documentation. According to the post fall assessment, resident #026 sustained physical injuries and the RN was informed of the incident shortly after it occurred.

The home's policy titled "Abuse, Neglect and Retaliation Prevention" last revised February 2017, indicated that the supervisor would review the definitions of abuse and neglect and if determined by the Ministry of Health and Long-Term Care (MOHLTC) abuse decision tree, notify the Director immediately.

According to the Long-Term Care Home Act, 2007, resident to resident physical abuse is defined as "the use of physical force by a resident that causes physical injury to another

resident".

During an interview with Manager #100, they indicated that the supervisor was required to notify the after hours pager (for incidents outside of business hours) and confirmed that the Director was not immediately notified of this incident. The incident was not reported to the Director until approximately 37 hours after the incident occurred. [s. 24. (1)]

2. Inspector #612 reviewed a CI report submitted to the Director in December 2016. The CI report described an allegation of staff to resident abuse that occurred the previous day.

The Inspector reviewed the home's investigation notes and found that on the day of the incident, PSW #145 reported the incident to RPN #147 who then reported to RN #143. The RN immediately began an investigation and separated resident #021 from staff #144.

The following day, after receiving shift report from RN #143, RN #124 and Manager #148, reported the allegation to the Director via the after-hours pager, after reviewing the MOHLTC abuse decision tree.

The Inspector interviewed RN #143 who confirmed that they did not immediately report the alleged incident. RN #143 stated that when an alleged incident was reported to them, they were to report to the Director immediately via the after-hours pager.

The Inspector reviewed the home's policy titled "Abuse, Neglect and Retaliation Prevention" last revised February 2017, which stated that any person must immediately report to a supervisor all suspected, alleged or witnessed incidents of resident abuse or neglect, regardless of their personal judgement that it may not be valid. If determined to be abuse, the supervisor would notify the Director immediately.

The Inspector interviewed Manager #101 who stated that the registered nurses were required to review the MOHLTC abuse decision tree and if they determined the allegation to be abuse, then they were required to immediately report to the Director. [s. 24. (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 ensuring that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: 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 licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

During stage one of the inspection, resident #015 was identified as having had worsening incontinence from the past to most recent Minimum Data Set (MDS) assessment.

Inspector #613 reviewed the home's policy titled "Continence Care and Bowel Management" last reviewed August 9, 2011, which indicated that each resident's bladder

and bowel functioning was to be reassessed using Tool #1 (three day continence assessment) on admission and at least quarterly as part of the quarterly review and if there was any change in the resident's health status.

A paper and electronic health care record review did not identify that resident #015's bowel and bladder functioning had been reassessed using the Tool #1 quarterly, as part of the quarterly review.

Inspector #613 interviewed RN #142, who was unable to locate an assessment in resident #015's paper or electronic health care record.

Inspector #613 interviewed Manager #101 who confirmed that the home's policy identified that resident #015's bowel and bladder functioning should have been reassessed using Tool #1 quarterly; they verified that this had not been completed for resident #015. [s. 51. (2) (a)]

2. During stage one of the inspection, it was identified that resident #001 had a continence decline from the admission MDS assessment to the 90 day MDS assessment. Upon review, the admission MDS assessment indicated that the resident was continent of bladder, however, the next quarterly MDS assessment indicated that the resident was occasionally incontinent of bladder.

The Inspector reviewed the resident's electronic health care record and noted a three day continence assessment implemented upon admission, however, no additional three day assessment had been completed.

Inspector #575 reviewed the resident's current plan of care. Under the focus of inability to control urination related to cognitive deficit, an intervention indicated that the resident was on a prompted/scheduled toileting schedule with specific times to toilet the resident.

During an interview with PSW #114, they indicated that resident #001 required one staff assistance for toileting and that the resident would often toilet themselves but if staff observed them heading to the toilet they would help. The PSW indicated that staff knew to take the resident to the toilet after meals, that the resident was not on a toileting routine, and that the resident would tell staff when they needed to use the toilet. In addition, the PSW indicated that the resident was continent during the day.

During an interview with PSW #119, they indicated that resident #001 was able to use

the toilet independently and that the resident was able to tell staff when they needed to use the toilet. The PSW indicated that the resident was continent during the day and not on a toileting routine and did not need to be prompted.

During an interview with Resident Assessment Instrument (RAI) staff #112, they indicated that the resident was assessed as moderately cognitively impaired with short and long term memory problems and staff were required to implement the prompted toileting routine.

The RAI staff #112 confirmed that resident #001 was not reassessed using Tool #1, and that they only implemented Tool #1 upon admission. [s. 51. (2) (a)]

3. During stage one of the inspection, it was identified that resident #004 had a continence decline from the admission MDS assessment to the 90 day MDS assessment. Upon review of the resident’s admission MDS assessment, Inspector #612 noted that resident #004 was continent of bowel and bladder. Resident #004 had a significant change in status MDS assessment completed approximately one month after admission, which identified that the resident was incontinent of bowel and bladder. Approximately three months later, a quarterly MDS assessment was completed which identified that the resident was frequently incontinent of bowel and bladder.

The Inspector reviewed the resident's electronic health care record and noted that a three day continence assessment was implemented upon admission, however, no additional three day assessments had been completed when the resident’s continence status changed.

During an interview with RAI staff #112, they confirmed that resident #004 was not reassessed using Tool #1, and that they only implemented Tool #1 upon admission. [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 ensuring that each resident who is incontinent receives an assessment that includes the identification of casual 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

Inspector #612 observed the lunch dining service in one area of the home on February 27, 2017, and noted that resident #035 was not offered a choice for their meal. The Inspector interviewed FSW #151 who stated that the staff on the unit knew what the residents liked, and therefore would give them what they thought the resident would like. They stated that some of the residents who received a certain texture diet were not able tell staff what they would like, however, resident #035 would likely be able to choose. The planned menu items for the specific texture diet were frittata or vegetarian chili with vegetable medley and rice, however the frittata was not available, therefore, old fashioned beef was substituted. Resident #035 was not offered a choice between the two meals.

Inspector #612 observed the lunch dining service in another area of the home on February 27, 2017, and observed that resident #037 had requested a certain dessert.

FSW #157 told the resident that they due to their specific diet type, they could not have that specific dessert, therefore, provided the resident with a second option. The Inspector reviewed the therapeutic spreadsheet and noted that the specific diet type alternative choice was different than what was offered to the resident.

On March 6, 2017, Inspector #612 observed the lunch dining service in a certain area of the home and noted that resident #036 was not offered a choice between the main meal or the alternative. Inspector #612 interviewed FSW #153 who stated that they were only provided with one option for the specific diet texture. The options listed on the therapeutic spreadsheet were vegetarian chili with vegetable medley and rice or old fashioned beef with green beans and potato.

On March 7, 2017, Inspector #612 observed the lunch dining service in a certain area of the home and observed that resident #016 was not offered a choice for their meal. FSW #156 stated that they were only provided with one option for the specific texture and therefore could not offer the resident a choice. The specific texture options listed on the therapeutic spreadsheet were honey ham with corn and potato or macaroni and cheese with herbed potato.

Inspector #612 reviewed the home's policy titled "Pleasurable Dining with Dignity" policy #04-34, last revised May 2014. The policy indicated that every resident would be offered a main choice and an alternate choice at the time of the meal service, unless contraindicated in the care plan.

Inspector #612 interviewed the Manager #158 and the Registered Dietitian. They both stated that all residents should be offered the main choice and the alternate choice at the time of meal service, for all therapeutic diets. [s. 71. (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 ensuring that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of, (b) the approved menu cycle; and O. Reg. 79/10, s. 72 (4).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that they maintained, and kept for at least one year, a record of, the approved menu cycle.

During an interview with Manager #158, they stated that they received the regular menu from Complete Purchasing Services Inc. Manager #158 and the Registered Dietitian (RD) would then review the menu with the Residents' Council and the Food Committee. The RD would then review the menu to ensure that it met the established dietary requirements. The RD would then sign their approval on the menu sheet. Manager #158 then completed the puree texture menu, based on the prepared items available through their supplier and added that to the therapeutic spreadsheet.

The Inspector reviewed the therapeutic spreadsheet for Cycle 2, Week 2 of 4, for a one week period. The Inspector noted that there were different options listed for the regular menu and the puree menu. On Monday, the lunch option for the regular diet were tomato basil frittata with a dinner roll and romaine salad or vegetable chowder soup with a deli meet sandwich. The puree option was puree frittata with puree peas or puree soup with Trepuree Vegetarian Chili, vegetable medley and rice. The dinner options for the regular menu were beef pot roast with oven brown potato and baked squash or rustic Italian cod with Santa Fe rice and pearl harvest blend vegetables. The puree dinner options were Trepuree old fashioned beef with green beans and potato or Trepuree whitefish newburg with broccoli and potato. The Trepuree options came prepared in a tray from the supplier.

The Inspector reviewed the menu sheets for the October 2016, Fall/Winter cycle. The Inspector noted that the RD had signed off on the menu, however, the menu sheets did not include the puree diet which was listed on the therapeutic spreadsheet.

The Inspector reviewed the home's policy from the Nutrition and Food Services manual titled, "Menus", last revised May 2014. The policy states that the menu plan, consisting of regular and therapeutic diets, textures, alternatives and resident suggestions will be reviewed by the Dietitian to ensure dietetic practice guidelines are met. The Dietitian will approve each cycle menu in writing by signing, dating and filing with the Nutrition and Food Manager.

Inspector #612 interviewed the RD who confirmed that the menu sheet they signed off on did not include the puree texture menu. They reported that when Manager #158 created the puree texture diet, there were some differences from the regular menu, and stated that they still reviewed the puree menu listed on the therapeutic spreadsheet, however, they did not maintain a record of the approved puree texture diet menu. [s. 72. (4) (b)]

2. The licensee has failed to ensure that the home had and that the staff of the home complied with policies and procedures for the safe operation and cleaning of equipment related to the food and production system and dining and snack service.

During the lunch dining service in a certain area of the home on March 6, 2017, Inspector #612 observed FSW #153 obtain the temperature of the beet salad and then the eggs without cleaning the temperature probe. The FSW then identified that they were required to sanitize the probe with an alcohol swab or under hot running water between food items. The FSW then obtained a wet paper towel and used it to clean the probe in between testing the cucumber salad and the beef.

On March 7, 2017, Inspector #612 observed the lunch dining service in a different area of the home. The Inspector observed FSW #152 obtain the temperature of the salad, then the soup and then the beef chili and did not clean the temperature probe between food items.

Inspector #612 reviewed the home's policy titled, "Food Thermometers" policy #08-44, last revised May 2014. The policy stated that when taking a series of temperatures at a meal, staff were to rinse the probe with hot water and wipe with a clean paper towel between each food sample or wipe the probe with an alcohol swab between each sample and rinse with hot water.

Inspector #612 interviewed Manager #158 who stated that when the staff were obtaining food temperatures, they should be cleaning the thermometer probes with an alcohol swab or washing the probe in between food items. [s. 72. (7) (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 ensuring that staff comply with with policies and procedures for the safe operation and cleaning of equipment related to the food and production system and dining and snack service, specifically, the "Food Thermometers" policy, 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 dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included a minimum, communication of the seven-day and daily menus to residents.

During stage one of the inspection, Inspector #612 observed the lunch dining service in a certain area of the home on February 27, 2017. The Inspector noted that the menu was

posted outside the dining room and stated that option one was a frittata with dinner roll and romaine salad and option two was vegetable chowder soup with a deli meat sandwich.

The Inspector interviewed the Dietary Aide who stated that there were food options available for all textures however the puree texture had prepared meals, which were sometimes different than what was offered on the regular menu. The Inspector noted on the therapeutic spreadsheet (which was not posted) that the first option was the same as the regular texture but the second option for the puree texture was puree soup with vegetarian chilli, vegetable medley and rice. The Inspector was unable to determine where this information was communicated to residents.

Inspector #612 interviewed Manager #158 who stated that the puree texture menu was not posted anywhere or communicated in any way to residents. [s. 73. (1) 1.]

2. The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

On March 6, 2016, Inspector #612 observed the lunch dining service in a certain area of the home. The Inspector observed that the hard boiled eggs, beet salad and cucumber salad were left sitting on a trolley with no ice or ice pack to maintain a cold temperature. The cold items were transported to a different area and temperatures were obtained by FSW #153. The FSW took the temperature of the beet salad, and it was 46 degrees Fahrenheit. The FSW proceeded to stir the beet salad until a temperature of 44 degrees Fahrenheit was reached, which was recorded on the Therapeutic Spreadsheet.

On March 7, 2017, Inspector #612 observed that the Tuscan salad was left sitting out in one of the home's dining rooms. A thermometer was sitting in the Tuscan salad and was reading 47.3 degrees Fahrenheit. There were no staff present in the dining room.

On March 8, 2017, Inspector #612 observed the lunch dining service in a certain area of the home. The Inspector observed that the ice cream was left sitting out on the counter and was not served to the residents until 40 minutes later. The Inspector reviewed the home's Therapeutic Sheet where the staff were to record the food temperatures and no temperature was recorded for the ice cream.

The Inspector interviewed FSW #153 who stated that cold items should be below 40 degrees Fahrenheit and should be stored in the fridge or cooling area of their cart until

they were ready to be served to better maintain the proper temperature. They also stated that dessert items should be kept in the fridge or cooling area of their cart until they were ready to be served to the residents.

The Inspector reviewed the home's policy titled "Food Distribution" last revised May 2014. The policy stated that cold foods would be no greater than between 40 to 45 degrees Fahrenheit at the point of service. The policy also stated that cold foods were to be kept refrigerated until ready to serve or transport and to serve frozen desserts, such as ice cream at the last minute directly from the freezer.

The Inspector interviewed the Manager #158 who stated that cold foods should not be removed from the fridge until staff were ready to serve so that the appropriate temperature range could be maintained. They stated that items, such as ice cream should be kept in the freezer, until ready to serve. [s. 73. (1) 6.]

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 ensuring that foods and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsible for resident care and situations that may lead to abuse and neglect and how to avoid such situations.

Inspector #612 reviewed a CI report submitted to the Director in December 2016. The report stated that on a certain date, a staff member approached RN #143 in regards to concerns of inappropriate behaviour between staff #144 and resident #021.

Inspector #612 interviewed staff #144 who stated that they had received training on the home's policy to promote zero tolerance of abuse and neglect of residents, however, the training did not include training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care or situations that may lead to abuse and neglect and how to avoid such situations.

Inspector #612 interviewed RPN #150 who stated that they completed their training on the home's policy to promote zero tolerance of abuse and neglect of residents via an online module. RPN #150 did not recall the training to include the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care or situations that may lead to abuse and neglect and how to avoid such situations.

Inspector #575 reviewed the home's abuse training module provided by Manager #100. The Inspector noted that the training did not include the relationship between power imbalances or situations that may lead to abuse and neglect. The home's policy titled "Abuse, Neglect and Retaliation Prevention" last revised February 2017, outlined that this training would occur.

Inspector #575 interviewed Manager #100 who stated that the training should have been included in the training module. After review of the module, they confirmed it was not included and should have been. [s. 76. (2) 3.]

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 ensuring that all staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsible for resident care and situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home, any changes and improvements identified in the review were implemented and a written record was kept of everything provided in clause a and b.

During an interview with Inspector #627, Manager #101 stated that medication incidents and adverse drug reactions that have occurred in the home were reviewed during the Professional Advisory Committee (PAC) meeting. For the year of 2016, two PAC meetings were held, in February and October.

A review of the minutes for the month of February 2016 revealed that the item "medication incident" had been deferred. A review of the minutes of the PAC meeting for the month of October 2016, failed to reveal any mention of a discussion related to medication incidents.

Manager #101 confirmed that quarterly reviews of all medication incidents and adverse drug reactions were not undertaken for the year 2016. [s. 135. (3)]

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 ensuring that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home, any changes and improvements identified in the review are implemented and a written record is kept of everything provided in clause a and b, to be implemented voluntarily.

WN #10: 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.

On February 27, 2017, Inspector #612 observed the lunch dining service in a certain area of the home. The Inspector observed PSW #122 touch one resident on the back, then served drinks to other residents and then went to assist another resident with their meal and did not perform hand hygiene in between tasks. The Inspector also observed FSW #151 remove dirty plates and then serve desserts to residents without performing hand hygiene.

On March 6, 2017, Inspector #612 observed the lunch dining service in a certain area of the home. The Inspector observed PSW #154 reposition a resident in their wheelchair, remove dirty plates and then sat down to assist another resident with their meal. The PSW did not perform hand hygiene between tasks.

On March 7, 2017, Inspector #612 observed the lunch dining service in a certain area of the home. The Inspector observed PSW #155 touch the door frame as they entered the dining room, rubbed a residents back, served a main meal to a resident, removed dirty plates and then served another meal to a resident. The PSW did not perform hand hygiene between tasks.

Inspector #575 reviewed the home's policy titled "Hand Hygiene Procedure", last revised August 23, 2016, which indicated that hand hygiene must be completed but not limited to: immediately before and after resident contact, after body fluid exposure risk, after touching soiled/contaminated objects and before handling or eating food.

Inspector #612 interviewed Manager #158 who stated that staff should have performed hand hygiene between tasks, for example, between removing dirty dishes and providing dessert. [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 ensuring that all staff participate in the implementation of the infection prevention and control program, specifically, hand hygiene, to be implemented voluntarily.

WN #11: 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. (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 licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in July 2016; the CI report described an allegation of staff to resident abuse.

The home's investigation determined that PSW #115 provided certain care to resident #027 without the assistance of another staff member. PSW #115 was disciplined for not following resident #027's plan of care; the resident's plan of care indicated that the resident required two staff for certain care.

During an interview with Manager #110, they confirmed that PSW #115 did not provide

care to resident #027 as specified in the resident's plan of care during the incident in July 2016.

As a result of inspection #2016_336620_0019, a compliance order under section 6. (7) was issued to the home on August 31, 2016, with a compliance date of September 16, 2016. This incident occurred before the compliance order was issued, therefore, no further action will be taken in regards to this non-compliance. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During stage one of the inspection, resident #011's family member informed Inspector #627 that resident #011 was no longer being toileted and that they wore an incontinence product which was changed as required.

A review of the most recent MDS assessment for the focus of bladder continence indicated that resident #011 was frequently incontinent.

A review of the current care plan revealed a focus for urinary incontinence with the potential to restore function indicating that the resident was to be toileted at specific times.

On March 7, 2017, Inspector #627 observed that resident #011 had not been toileted at two specific times.

During an interview with the Inspector, PSW #140 confirmed that the resident had not been toileted at two specific times, however they had received certain continence care during that time period.

During an interview with the Inspector, PSW #139, PSW #140 and RPN #138 stated that resident #011 was very seldom toileted and that the toileting schedule was no longer followed as toileting the resident on a fixed schedule increased the resident's responsive behaviours. They further stated that the goal now was containment to keep the resident dry and comfortable. RPN #138 confirmed that the care plan had not been revised when the resident's needs changed. [s. 6. (10) (b)]

WN #12: 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 ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On February 28, 2017, Inspector #575 noted a call bell in a certain area of the home did not activate when pressed by the Inspector. The Inspector brought forward the concern to a PSW at that time.

On March 6, 2017, Inspector #575 noted that the same call bell did not activate when pressed by the Inspector.

During an interview with RN #124, they were unable to activate the certain call bell and they indicated they would notify maintenance to replace it.

During an interview the following day, Manager #120 confirmed that staff were to notify maintenance when call bells were noted to need replacing or were not working. Manager #120 confirmed that they had received notification regarding the call bell identified by the Inspector, and they had replaced the call bell cord. They further indicated that the specifc call bell cord did work, however, it needed to be pressed a certain way; these types of call bell cords were being replaced as needed throughout the home to a new cord which had a protruded red button. [s. 15. (2) (c)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in October 2016. The CI report alleged potential staff to resident abuse, indicating that resident #028 had unknown bruising to several areas of their body. The CI report indicated that the investigation was ongoing.

The Inspector reviewed the investigation notes from the incident which indicated that the investigation was completed the following day. The investigation determined that the bruising was attributed to the use of certain medication that was subsequently held and discontinued.

The home's policy titled "Abuse, Neglect and Retaliation Prevention" last revised February 2017, indicated that management would submit a final report to the Director with the results of every investigation conducted under this policy and any action the home takes in response to any incident of abuse or neglect.

During an interview with Manager #101, they confirmed that they did not update the CI report with the outcome of the investigation. [s. 23. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

During stage one of the inspection, resident #006 was identified via their most recent MDS assessment as being bedfast.

Inspector #613 observed resident #006 on March 2, 6, 7 and 8, 2017, in their room; resident #006 was not observed to be out of their bed or room, during these observations.

A review of resident #006's plan of care did not identify their sleep patterns and preferences.

The Inspector interviewed RN #124, who verified that resident #006's plan of care did not identify an interdisciplinary assessment of the resident's sleep patterns and preferences. RN #124 stated that it was resident #006's choice to stay in their room and that the resident had been residing at the home for awhile, therefore, staff knew the resident's preferences.

The Inspector interviewed Manager #101 who was unaware resident #006 was staying in their bed and room all day. Manager #101 confirmed that an interdisciplinary assessment of resident #006's sleep patterns and preferences should have been identified in their plan of care. [s. 26. (3) 21.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location.

On February 27, 2017, during an initial tour of the home, Inspector #627 observed two inspection reports posted in front of the Clinical office: Resident Quality Inspection (RQI) report 2016_332575_0016 and Critical Incident report 2016_336620_0019.

A review by the Inspector of the inspections completed in the last two years, indicated that the following five public inspection reports were not posted:
Follow Up (FU) report 2015_395613_0006;
Complaint (CO) report 2015_395613_0006;
FU report 2015_282544_0027;
CO report 2015_283544_0028; and
RQI report 2015_336620_0019.

During an interview with the Inspector, Administrative Assistant #103 stated that the reports for the last two years had been posted, but the reports for 2015 had just been removed. They further stated that the reports would be reposted. [s. 79. (3) (k)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in July 2016. The CI report described an allegation of resident to resident abuse that occurred the previous day. According to the CI report and the home's investigation documentation, resident #025 pushed resident #026 which caused resident #026 to fall and sustain physical injuries.

Inspector #575 reviewed the post fall assessment which indicated that resident #026's Substitute Decision Maker (SDM) was notified of the incident the following day, almost 12 hours after the incident occurred.

During an interview with Manager #100, they indicated that they did not expect the staff to notify the resident's SDM when the incident occurred. They indicated they would only notify the SDM of a significant injury, or an injury which required transfer to hospital.

The home's policy titled "Abuse, Neglect and Retaliation Prevention" last revised February 2017, indicated that the resident's SDM would be immediately notified upon the home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident or distress to the resident that has the potential to be detrimental to the resident's health and well-being. [s. 97. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following: the long-term actions planned to correct the situation and prevent recurrence.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in October 2016. The CI report alleged potential staff to resident abuse, indicating that resident #028 had unknown bruising to several areas of their body. The CI report indicated that the long-term actions planned to correct the situation and prevent recurrence were "to be determined".

The Inspector reviewed the investigation notes from the incident which indicated that the investigation was completed the following day.

During an interview with Manager #101, they confirmed that they did not update the CI report with the long-term actions to prevent recurrence. [s. 104. (1) 4.]

Issued on this 28th day of March, 2017

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

Original report signed by the inspector.