Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 23, 2019	2019_598570_0017	004709-18, 007298-18, 009381-18, 012442-18, 016181-18, 018062-18, 030640-18, 012261-19	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

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

SAMI JAROUR (570), JENNIFER BATTEN (672), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 8, 9, 12-16, 19-23, 26, and 27, 2019

The following intakes were inspected during this inspection:

- Log #: 004709-18, related to a Critical Incident Report regarding an environmental hazard.
- Log #: 007298-18, related to a Critical Incident Report regarding an environmental hazard.
- Log #: 009381-18, related to a Critical Incident Report regarding an outbreak
- Log #: 012442-18, related to a Critical Incident Report regarding a medication incident
- Log #: 016181-18, related to a Critical Incident Report regarding an allegation of staff to resident physical abuse
- Log #: 018062-18, related to a Critical Incident Report regarding an allegation of resident to resident physical abuse
- Log #: 030640-18, related to a Critical Incident Report regarding an fall incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status
- Log #: 012261-19, related to a Critical Incident Report regarding an incident of missing resident

PLEASE NOTE: A Written Notification related to LTCHA,2007, s. 20. (1), was identified related to Log #016181-18 and issued in complaints inspection report #2019_715672_0010 that was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), RAI Coordinator, Resident Services Coordinator (RSC), Office Manager, Environmental Services Manager (ESM), Physiotherapists (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), ward clerks, and residents.

During the course of the inspection, the inspector (s), toured the home, observed staff to resident interactions, resident to resident interactions, reviewed clinical health records, licensee's investigations related to associated CIRs, reviewed water temperature logs, reviewed policies related to water temperatures monitoring.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 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 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).

Findings/Faits saillants :

1. The licensee had failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the 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.

The home had submitted a Critical Incident Report (CIR) to the Director on an identified date, for an incident that caused an injury to resident #001 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated staff reported an injury to resident #001's specified body part. The resident was noted to hold on to specified body part and facial grimacing was observed. The resident was sent to hospital and diagnosed with an injury to a specified body part.

A review of resident #001's clinical records on Point Click Care (PCC) indicated the resident was identified at risk for falls.

A review of progress notes for resident #001 on PCC indicated:
- On an identified date and time, the resident had a witnessed fall; the resident was sent to the hospital and diagnosed with an injury to a specified body part.
- On an identified date and time, the resident had unwitnessed fall. Resident was seen sitting next to their bed at an identified time.
- On an identified date and time, staff reported an injury to an identified body part. The resident complained of pain upon touching the resident's specified body part. The resident was noted to be holding on to specified body part and facial grimacing was observed. The resident was transferred to hospital and admitted with an injury to a specified body part.

- On an identified date and time, the resident had unwitnessed fall, the resident self-transferred out of bed. The resident had an injury to a specified body part.
- On an identified date and time, the resident was noted to have self-transferred out of bed, after sustaining an initial injury from previous self transfer.
- On an identified date and time, falls prevention interventions put in place including using a a specified device for falls prevention.

A review of physiotherapy assessment notes completed on a specified date indicated resident #001 required one person assist for transfer. The notes further indicated that the resident should have all falls prevention measures in place including using a specified device. Resident had a tendency to unsafely self transfer at times.

A review of the plans of care for resident #001, completed on two specified dates, indicated under physiotherapy focus: resident tends to self transfer at times. Resident should have all falls prevention measures including a specified device. Resident tends to unsafely self transfer at times and at risk of falls. Review of plan of care for resident #001, review date completed on specified date under falls prevention focus, the use of the specified device was discontinued. The current plan of care resident #001 was revised on same date of a recent fall, and indicated same specified device was used to prevent falls.

During an observation on August 09, 2019, at 1217 hours, resident #001 was observed seated and the resident did not have the specified device for falls prevention.

During observations on August 13, 14 and 15, 2019, at 0934 hours, 1256 hours and 1127 hours, resident #001 was observed seated with the specified device used for falls prevention was in place.

An interview with PSW #100, indicated the resident required one person assist for transfers, used a specified device for mobility, tends to self transfer and was at risk for falls. The resident had a specified device for falls prevention attached when seated.

An interview with PSW #104, indicated the resident continued to get out of the mobility device to go to bathroom. The PSW indicated that a specified device used when in bed and when seated was recently used after the resident had a recent fall and had a minor injury to a specified body part; Prior to that the specified device was not used for the resident.

An interview with PSW #108, indicated the resident was at risk for falls, required one person assist for transfer and used a mobility device. The PSW indicated the resident needed to be monitored all the time for safety and needed to have a specified device for safety due self transferring and toileting.

An interview with RPN #105, indicated that resident #001 required one person assist with transfers and the resident was at risk for falls due to self transferring. The RPN indicated that the specified device for falls prevention was not used until the resident sustained a recent fall, although it was recommended by the physiotherapist for falls prevention.

An interview with RPN #109, indicated that resident #001 was at risk for falls due to cognitive decline, attempts to self transfer and self toilet. The resident continued to be monitored. The RPN indicated that the resident had the specified device for falls prevention after the incident of a recent fall. The RPN indicated they were not aware that the use of specified device for falls prevention was resolved and was not in use prior to the recent fall incident. The RPN indicated that the resident needed to have the specified device due to self transferring and toileting.

An interview with the physiotherapist (PT), indicated that resident #001 was at risk for falls and confirmed that the resident required the use of a specified device for falls prevention. The physiotherapist indicated that the specified device was recently installed after the resident sustained a recent fall and that they were not aware that the device was discontinued at an earlier specified date.

An interview with RPN #154, confirmed that they updated resident #001's plan of care on specified date, and discontinued the use of a specified device for falls prevention for resident #001. RPN #154 indicated no awareness of the physiotherapist's notes recommending a the specified device and did not have a discussion with the physiotherapist when the use of the device was discontinued when the plan of care was updated.

An interview with the Assistant Director of Care (ADOC) acknowledged upon review of resident #001's plans of care and the physiotherapist's assessment on specified date, that there was a gap in communication between staff regrading the use of the specified device for the resident.

Staff and others involved in the different aspects of care did not collaborate with each other in the development and implementation of the plan of care for resident #001 so that

the different aspects of care are integrated and are consistent with and complement each other specific to the use of specified device for falls prevention. [s. 6. (4) (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 staff and others involved in the different aspects of care of the resident collaborate with each other in the 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents does not exceed 49 degrees Celsius.

During the course of this inspection, Inspector #570 noted that the water was hot in a common bathroom accessible to residents in the centre core area of the second floor.

On August 19, 2019, Inspector #570 took water temperatures in five different locations with ESM present. All temperatures taken in all five locations in five different dates indicated that the temperatures were above 49 degrees. Inspector #570 checked water temperatures in same locations on August 20, 21, 22, 23 and 26, 2019, with hot water temperatures found exceeding 49 degrees in most of the locations:

Review of water temperatures logs recorded by registered staff from June 1, 2019, to August 21, 2019, indicated the water temperatures exceeded 49 degrees Celsius at residents' basins and in the dining rooms as follows:
- Month of June 2019, water temperatures were above 49 degrees in 17 shifts.
- Month of July 2019, water temperatures were above 49 degrees in 10 shifts.
- From August 1 to August 21, 2019, water temperatures were above 49 degrees in 20 shifts.

An interview with ESM, indicated no awareness of the temperature's logs completed by the nursing staff until it was brought to their attention by Inspector #570. The ESM indicated that when they reviewed the maintenance care system they could only locate a total of five water temperatures readings reported as exceeding 49 degrees Celsius from June1 to August 21, 2019.

An interview with the Executive Director (ED), indicated no awareness of the temperature's logs completed by the nursing staff and that no concerns related of hot water temperatures were reported to them until it was brought to their attention by Inspector #570. Upon review of the hot water temperature's logs, the ED acknowledged that the water temperatures exceeded 49 degrees during different shifts and that the home started taking measures to fix the concerns with corporate office involved.

The licensee did not ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents was maintained at 49 degrees Celsius or

less. [s. 90. (2) (g)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that immediate action is taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius.

During the course of this inspection, Inspector #570 noted that the water was hot in a common bathroom accessible to residents in the centre core area of the second floor.

According to water temperature records recorded by registered staff on from June 1, 2019, to August 21, 2019 for water temperatures taken at the hand basins in resident rooms and dining rooms, the hot water exceeded 49 degrees Celsius as follows:
- Month of June 2019, water temperatures were above 49 degrees in 17 shifts.
- Month of July 2019, water temperatures were above 49 degrees in 10 shifts.
- From August 1 to August 21, 2019, water temperatures were above 49 degrees in 20 shifts.
Multiple missing readings were noted as follows:
June 1-30, 2019 – 37 missing readings not recorded.
July 1-31, 2019 – 33 missing readings not recorded.
August 1-21, 2019 – 14 missing readings not recorded.

The above hot water temperatures records review indicated, the temperatures ranged from 49.4 – 51.5 degrees Celsius. No follow up action was documented to determine what actions were taken and what the water temperatures were after interventions were implemented.

Inspector #570 requested policies from DOC and ESM related to hot water monitoring system and the following two documents were provided the Inspector:
- Procedure – LTC – Bath and Shower Guidelines, index 14-O10.02, reviewed March 31, 2019, indicated "the temperature of the hot water serving all bath tubs and showers by residents is maintained at a temperature of at least 40 degrees Celsius and a maximum of 49 degrees Celsius. Immediate action will be taken if the temperatures is outside of these ranges.

- Marquise – Environmental Services Manual, Index I.D. ES E-10-05, recording Log Book – Daily Recoding Log.

Procedure:

1. Record all of the following on the Daily Records Form daily for a period on one (10 month:
a) Domestic hot water supply resident areas.
b) Domestic hot water supply kitchen
c) Resident area morning shift
d) Resident area afternoon shift
e) Resident area night shift
2. Domestic hot water for resident care areas must be between 40 and 49 degrees Celsius.
3. Report all readings below 40 or above 90 degrees Celsius immediately to the contract Environmental Services manager (ESM) and Administrator/Executive Director (ED)
4. The daily recording log will be kept in the boiler room in close proximity to the mixing valve.
5. Readings will be done by the ESM or designate Monday to Friday as per above and the nurse in-charge/designate on weekends.
6. Hot water temperature shall be monitored daily at the source and once per shift in random locations where residents have access to hot water. Resident access areas shall be completed by nursing department.
7. At the completion of each month, store form in the Daily Recordings Log Book and start new form.

Notes:
- The ESM or in-charge person must take immediate action for all readings below and above required temperature. The corrective actions taken will be documented beside the day of the occurrence on this sheet under corrective action and must include signature. Reading must be taking at the boiler once per day and the resubmit care areas every shift.

An interview with ESM, indicated no awareness of the temperature's logs completed by the nursing staff until brought to their attention by Inspector #570. The ESM indicated that when they reviewed the maintenance care system they could only locate a total of five water temperatures readings reported as exceeding 49 degrees Celsius from June1 to August 21, 2019. The ESM indicated, when they became aware of the hot water temperature exceeding 49 degrees, they called the repair company to adjust the water temperature at the boiler.

The above-mentioned policy did not provide staff with any specific immediate corrective actions to take when hot water temperatures exceeds 49 Celsius. The policy included a

copy of the exact legislative wording found under section 90(2) in Ontario Regulation 79/10 without any additional guidance. [s. 90. (2) (h)]

3. The licensee has failed to ensure that procedures were developed and implemented to ensure that, if the home is not using a computerized system to monitor the water temperature, the water temperatures are monitored once per shift in random locations where residents have access to hot water.

Inspector #570 requested the licensee's policy/procedures of monitoring water temperatures. The following policy was provided to the inspector: Marquise – Environmental Services Manual, Index I.D. ES E-10-05, recording Log Book – Daily Recoding Log.

Procedure:
1. Record all of the following on the Daily Records Form daily for a period on one (1) month:
a) Domestic hot water supply resident areas.
b) Domestic hot water supply kitchen
c) Resident area morning shift
d) Resident area afternoon shift
e) Resident area night shift
- Reading must be taking at the boiler once pers day and the resident care areas every shift.

According to the Environmental Services Manager, the home is not using a computerized system to monitor the water temperature and the water temperatures are monitored once per shift by the nursing department; the ESM indicated no awareness of any forms used for that purpose and had no records of water temperatures taken by registered staff and that they only take water temperatures at the boiler daily. The ESM indicated that any readings above 49 degrees Celsius will come to their system under Maintenance Care.

The DOC provided Inspector #570 water temperatures logs with recorded temperatures for the months of June, July and August 2019. The logs identify three daily shifts (Nights, Days, and Evenings) with temperatures recorded in residents rooms and residents home areas' dining room. The logs, however, did not include any listing of bathtub or shower locations in the home.

A review of the water temperatures logs for the months of June, July and August, 2019,

indicated temperatures were not recorded on each shift in June with 37 entries noted missing, July with 33 entries missing and upto August 21, 2019, with 14 entries missing. There was no documented evidence that those logs were reviewed by any person to determine accuracy, trends and missing entries.

An interview with RN #134 indicated that water temperatures are taken once every shift through out the building as per random assignment locations identified in the water temperatures form. The RN indicated that they have not taken water temperatures on two occasions when they were attending to emergency situations with residents.

An interview with ESM, indicated no awareness of the temperature's logs completed by the nursing staff until brought to their attention by the inspector. The ESM indicated that when they reviewed the maintenance care system they could only locate a total of five water temperatures readings reported as exceeding 49 degrees Celsius from June1 to August 21, 2019.

An interview with the Executive Director (ED), indicated no awareness of the temperature's logs completed by the nursing staff and that no concerns related to hot water temperatures were reported to them until brought to their attention by the inspector.

The licensee did not ensure that the water temperature was monitored once per shift in random locations where residents have access to hot water. [s. 90. (2) (k)]

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 to ensure that:
- the temperature of the water serving all bathtubs, showers and hand basins used by residents is 49 degrees Celsius or less
- staff take appropriate and immediate action to reduce the water temperature in the event that it exceeded 49 degrees Celsius, and
- the water temperature was monitored once per shift in random locations where residents have access to hot water, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

A Critical Incident Report (CIR) was submitted to the Director regarding a medication incident which occurred on an identified date, involving resident #010. According to the CIR, on an identified date and time, RPN #116 prepared resident #011's medications, and brought them to administer to the resident during a specified meal time. When RPN #116 arrived, they observed that resident #011 was not positioned properly, therefore set the cup of medications down on a table to assist the resident with repositioning. When RPN #116's back was turned to the medication cup, resident #010 reached over and took the medications which were meant for resident #011. Following the medication incident, resident #010's health condition was monitored, and was noted to have a change in an identified set of vitals. Some of the medications resident #010 ingested had

specified effect, therefore the resident was transferred to hospital for further assessment, where they were admitted with a specified diagnosis.

Review of the medication administration record (MAR) of a specified month for resident #011 listed five medications which were administered on a specified date, that were ingested by resident #010.

During an interview, RPN #116 indicated on an identified date and time, they had approached resident #011 to administer medications. Resident #011 was observed to be slouching in their wheelchair, therefore RPN #116 set down the medication cup on a table, and assisted resident #011 with repositioning. Following the repositioning, RPN #116 observed that the medication cup was missing and resident #010, who was sitting at the the table with resident #011 was chewing resident #011's medications, and could not get resident #010 to spit the medications out prior to their swallowing them. RPN #116 indicated they checked resident #010 following the medication incident and contacted the Nurse Practitioner to come and assess the resident. Physician #138 was contacted, and an order was received to transfer resident #010 to the hospital for further assessment and the resident was admitted to the hospital. RPN #116 further indicated that they were aware that resident #010 was sitting at the dining room table at the time they placed the medication cup down and turned their back, and that resident #010 had a diagnosis of advanced cognitive impairment with some unpredictable behaviours exhibited.

During an interview, the DOC indicated the expectation in the home was that no medications were administered to a resident without a valid prescription from the attending physician, and medications were never to be left in an area unattended.

The licensee failed to ensure that no drugs were administered to a resident in the home unless they had been prescribed for the resident, when resident #010 ingested medications meant for resident #011 after they were left unattended on a dining room table. [s. 131. (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 no drug was administered to a resident in the home unless the drug had been prescribed for the resident, to be implemented voluntarily.

WN #4: 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. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies and was secure and locked.

During resident observations on August 20, 2019, at 1040 hours, Inspector #672 observed several opened boxes stored outside of the rear elevator on the second floor, beside the nursing supply room. This area was observed to be a resident accessible area. Upon closer inspection, Inspector #672 observed the boxes contained the following medications:

12 350ml bottles of Almagel 200
12 500ml bottles of Milk of Magnesia 400mg/5ml
1 box containing bottles of Acetaminophen 325mg
24 bottles of Loris-1% PVP Iodine Solution
20 jars of Vitarub

During an interview on August 20, 2019, at 1415 hours, the DOC indicated the expectation in the home was that whenever a delivery arrived, the DOC was supposed to be immediately informed and would then either put the delivery away or call the charge nurse to put it away. The DOC indicated they were not aware of the supply delivery that had arrived that day, which was why the medications had sat out in a resident accessible area for several hours. The DOC further indicated the expectation in the home was for all medications to be stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies and was kept secure and locked. Following the interview, the DOC moved the boxes into the nursing supply room, which was not a resident accessible area and kept locked at all times.

On August 20, 2019, at 1520 hours, Inspector #672 observed another delivery of boxes sitting in the same area outside of the rear elevator on the second floor, beside the nursing supply room. These boxes were observed to contain Cavilon spray, Cavilon cleanser, body wash, facial tissues, and other nursing supplies. During a second interview at 1530 hours, the DOC indicated they had not received notification regarding the second delivery arriving to the home and was not aware of the second delivery sitting outside of the nursing supply room.

The licensee failed to ensure that medications were stored in an area or a medication cart which was kept secured and locked, when a supply delivery of government stock medications arrived at the home and as left sitting in a resident accessible area for several hours. [s. 129. (1) (a)]

Issued on this 24th day of September, 2019

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

Original report signed by the inspector.