Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 26, 2016	2015_356618_0018	CSC-021592-15	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

BRADFORD VALLEY
2656 6th Line Bradford ON L3Z 3H5

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

CECILIA FULTON (618), JANET GROUX (606), NITAL SHETH (500)

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): October 22, 23, 26,27,28,29,30, November 2,3,4, 2015.

The following Critical Incident inspections were inspected during the course of this RQI: #000838-14,#001592-14, #010758-15, #010162-15, #005568-15, #1010880-15, #004341-15, #003242-14 and the following complaint intake inspection was conducted: #000838-14

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Associate Directors of Care (ADOC), Director of Dietary Services, Director or Environmental Services, Food Service Supervisor (FSS), Restorative Care Aid (RCA), Physiotherapist (PT), Physiotherapy Assistants (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Cook, Dietary Aides, Housekeeping Aides, Laundry Aid, Residents and Family members.

During the course of the inspection, the Inspectors conducted observation of Residents and homes areas, medication administration, meal service delivery, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **2 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	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

On October 22, 2015, the inspector observed contact precaution signs posted on a number of residents' doors. There were no isolation precaution stations set up outside of these resident rooms.

Review of the home's policy entitled 'Isolation Precaution Stations # 1X-G-10.80', states that when it is determined that a resident must be placed on additional precautions, an isolation precaution station will be set up and stocked outside of resident's room.

An interview with PSW #140 and RPN #141 revealed that the above residents rooms did not have an isolation precaution station set up because the home is waiting for the supplies to come in.

An interview with ADOC #107 and the DOC confirmed that the isolation precaution stations were not set up for the above mentioned rooms as the home was waiting for the storage carts to come in and not the supplies. [s. 8. (1)]

2. On October 22, 2015, the inspector observed contact precaution signs posted on the doors of a number of residents' rooms, and noted that some of these above mentioned rooms were shared by two residents. Further observations on the same day, the inspector noted contact precaution signs posted on the some residents' doors and there were no isolation precaution stations set up outside of these residents' rooms.

Review of the home's policy entitled 'Monthly Infection Control Summary Record 1X-E-10.20 current revision January 2015 indicates that the prevalence of infections will be calculated on a monthly basis and the Infection Control Practitioner will:

-complete the monthly Infection Control Summary Record using the information form the Daily Surveillance Record
-analyze and interpret the summarized information on infections,
-complete the monthly QIA indicators in accordance with the indicator definition and using the monthly summary receive from the contract laboratory,
-initiate any education, training, or precautions that may be indicated as a result of the analysis and,

-highlight any trends or patterns and report to the DOC and the Professional Advisory Committee (PAC).

An interview with PSWs #140, #104, RPNs # 101, #136, and #141, revealed that resident (s) residing in the above mentioned rooms have an infection requiring staff to use personal protection equipment when providing their care to prevent further spread of infection and confirmed that the home has a high number of residents with similar precautions.

An interview with ADOC #107, the home's Infection Control Program lead revealed that the home has several residents with a certain infection and confirmed that the spread of the this infection has increased since 2014. Further interview with ADOC #107 revealed that the home did not complete an analysis and confirmed that the above policy was not followed. [s. 8. (1)]

3. A review of the home's policy #VII-G-20.80, entitled "Height Measurement", dated October 2015, indicated that all resident's heights will be taken and recorded within 48 hours of admission and then taken annually.

A review of one resident's plan of care revealed that the height was missing in 2013.

Interview with registered staff #122 confirmed that the resident's height was missing in 2013.

Interview with FSS #103, director of dietary services #130 and DOC #131 confirmed that the height should be taken on admission and annually there after. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

The home's monthly analysis and training records were not available for review when requested by the inspector.

On October 22, 2015, the inspector observed, in a shared bathroom, two unlabelled toothbrushes, and one unlabelled washbasin.

An interview with Personal Support Worker revealed that the toothbrushes and the washbasin should have been labelled and were not.

An interview with the ADOC revealed that it is the practice of the home that personal care items as mentioned above are labelled. [s. 229. (4)]

2. On October 22, 2015, the inspector observed a sit stand lift in an identified home area to have dirty handles.

An interview with PSW #145 and RPN #146 revealed that it is the home's expectation for staff to clean and disinfect the lift after each resident use and this was not done.

PSW #145 informed the inspector that the lift handles were cleaned and disinfected after this was brought to their attention.

An interview with ADOC #115 confirmed that the expectation is for the staff to clean the lift with the wipes after use. [s. 229. (4)]

3. The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis (TB) within 14 days of admission, unless the resident has already been screened at sometime in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Review of the home's practice for tuberculosis screening reveals that a chest x-ray is to be obtained for all admitted residents who are 65 year of age and older. A resident who met this criteria and was admitted in 2015 did not receive this screening which immunization records revealed was required.

Interview with ADOC #107 regarding the Long Term Care Confirmation Checklist Infection Control Prevention and Control dated October 27, 2015, revealed that the home follows public health's best practice for tuberculosis screening which requires that residents admitted are screened for TB with 14 days of admission with the following criteria:
1. Chest x-ray and clinical symptom checklist for those 65 years of age and older,
2. step mantoux for those 64 years of age and under, and confirmed that this resident required a chest x-ray.

Interview with RN #116 revealed that this resident had a physician order for a chest x-ray but a requisition was not completed. RN #116 revealed they had contacted STL laboratory and confirmed that the laboratory did not have chest x-ray results for this resident.

RN #116 confirmed that they had completed a requisition for a chest x-ray and faxed it to the lab. [s. 229. (10) 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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

On October 22, 2015, the inspector observed a contact precaution sign on a resident's door.

Review of this resident's written plan of care revealed resident has a diagnosis but no further information related to goals and interventions was included.

Interview with RPN #136 revealed that this resident had a diagnosis which required certain interventions. These interventions should have been in the plan of care and were not. The resident's plan of care was updated on November 4, 2015 after it was brought to the attention of the home by the inspector. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan of care for a resident states that resident is to receive denture cleaning after meals.

Interview with the resident revealed that this care is not being offered or provided.

Interview with PSW # 120 and PSW # 128 revealed that they are not aware of the contents of the plan of care with regards to providing denture cleaning after meals to this resident and that they are not offering or providing this care to the resident.

Interview with registered staff # 116 revealed that providing after meal denture cleaning is in the plan of care and that the care should be offered and provided.

Interview with DOC #131 confirmed that it is the expectation of the home that staff be aware of the contents of the plan of care and that they provide the care as specified in the plan of care. [s. 6. (7)]

3. On October 22, 2015, at 1230 hours, on an identified home area, the inspector observed PSW #100 feeding a resident milk, water and soup of an identified consistency that was contrary to the specified consistency in the resident's plan of care.

Interview with PSW #100 indicated that they had been feeding the identified fluids to the resident for the last three days and it was communicated to the RPN #101. Sometimes the PSWs add thickener to the resident's fluids as they feel the resident tolerates a thicker consistency better.

Interview with RPN #101 confirmed that PSWs are not allowed to change fluid consistency for residents. PSW #100 never communicated to RPN #101 that the resident required a different fluid consistency. RPN #101 indicated that the resident should be provided fluids as per the plan of care. PSW #100 did not follow the care plan. RPN #101 indicated that they would make a referral to the dietitian to assess the resident's fluid consistency.

A review of the progress notes indicated that the dietitian assessed the resident on October 22, 2015, and it was recommended to continue with the specified fluid

consistency as per the plan of care. FSS #103 witnessed PSW #100 feeding the identified fluids to the resident.

Interview with FSS #103 confirmed that PSWs are not allowed to make any change in residents' diet, texture or fluid consistency. PSW #100 should have provided fluids as per the plan of care to the resident and should have communicated any concerns regarding the resident's fluid tolerance to the registered staff. [s. 6. (7)] (500) [s. 6. (7)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On October 30, 2015, at 1030 hours, the inspector observed the kitchen and found the entire floor, underneath equipment and the dish machine was unclean. There was water on the floor behind the kettle close to the wall. There was black dust found underneath most of the equipment. The hand washing sinks were not clean. The ceiling and walls all over the kitchen, especially in the production area had lots of stains on them including food stains. Hot hold equipment, the steamer, and oven had stains and unclean walls. The steamer had a large area of rust on it. There was sticky black greasy material found on the can opener. The floor space in between the hot hold equipment and the preparation table had dust it. There were two power outlets in that space that were covered with dust and sticky greasy material. Two black rags on the floor were not clean and had food stains on them. Preparation tables and shelves were unclean. Hot hold carts for the Simcoe and Harvest resident home areas were not clean on the inside. There was a small white colored toaster which was unclean on the first floor servery.

Interview with the cook #117 confirmed that above mentioned areas were unclean and required cleaning.

Interview with FSS #103 confirmed the inspector's findings of unclean areas and that they required cleaning. FSS #103 indicated that the home has a cleaning schedule for all equipment and staff are to comply with the schedule. [s.15. (2) (a)] (500) [s. 15. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring new items.

On October 29, 2015, the inspector and Restorative Care Aide (RCA) #112 observed three residents' who's eyeglasses were not labelled.

Interview with RCA #112, who revealed they are responsible for labelling residents' glasses in the home, confirmed that the above residents' eyeglasses should be labelled but were not. The above residents' glasses were labelled after the inspector raised the issue.

Interview with ADOC #115 confirmed that it is the home's practice to label residents' glasses on admission and as required. [s. 37. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

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 each menu provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time.

Interview with a resident revealed that there is not enough variety of foods on the menu. Interview with another resident revealed that they are receiving the same food with the

same taste all the time.

Interview with PSW #125 revealed that residents frequently complain about repetitious food offerings on the unit.

A review of the home’s spring summer menu, 2015 revealed that chicken was planned six times in week one and four times in week three and four. Cheese was planned five times in week two.

Interview with FSS #103 confirmed that the chicken and cheese are repeating many times in the current menu.

Interview with director of dietary services #130 confirmed that they are aware about repetition of food in the current menu and will address residents' concern in the new menu that is planned to be implemented in a few days. [s. 71. (2) (b)] (500) [s. 71. (2) (b)]

2. The licensee has failed to ensure that the planned menu items are offered and available at each meal.

On October 22, 2015, at 1230 hours, on an identified home area dining room the inspector observed the posted menu which indicated pepperoni pizza was one of the lunch choices and fresh mixed berries was one of the dessert choices.

The inspector observed the kitchen serve cheese pizza and cherries to residents. Interview with the dietary aide #102 confirmed that the kitchen provided cheese pizza and cherries as pepperoni pizza and fresh mix berries were not available.

Interview with RPN #101 indicated that the planned menu should have been provided to residents.

Interview with FSS #103 and director of dietary services #130 confirmed that pepperoni pizza and fresh mixed berries should have been served to residents as indicated in the planned menu. Due to unavailability the planed items were not offered to residents. [s. 71 (4)] (500) [s. 71. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system are prepared using methods to preserve taste, nutritive value, appearance and food quality.

Interview with three residents revealed that residents do not like the taste of the food and the way the food has been cooked.

Interview with RPN #126, and PSW #125 confirmed that residents often complain about the food.

On October 30, 2015, at 1115 hours, in the kitchen, the inspector observed the menu for the Friday of week two included cream of mushroom soup, turkey sausage on bun, and cheese plate.

Interview with cook #118 confirmed that she did not follow the recipe for pureed cream of mushroom soup and for pureed cottage cheese. She did not add thickener to puree the cottage cheese because she thought the pureed cottage cheese was okay and did not require thickener.

A review of the recipe for minced and pureed turkey sausage on bun indicated to use the actual recipe for turkey sausage on bun for minced a pureed. Minced turkey sausage on bun required gravy to be added and pureed turkey on a bun required gravy, milk, and margarine to be added.

Interview with cook #117 confirmed that they had not followed standardized recipe for

minced and pureed turkey sausage. They minced the turkey sausage in the machine and they pureed the turkey sausage by only adding water into it. They did not add any gravy to the minced turkey sausage, and did not add any milk, margarine or gravy to the pureed turkey sausage. They confirmed that they did not mince or puree the actual recipe "turkey sausage on bun", they provided separate pureed bread to the kitchen staff for residents.

Interview with FSS #103 and director of dietary services #130 confirmed that the cooks are not allowed to make any change in standardized recipes. If they have any concern they need to communicate it with the FSS. The FSS will need to approve a change, update the recipe and sign it. The cooks are expected to follow recipes at all times to preserve taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

WN #8: 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 the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. The required information for the purposes of subsections (1) and (2), (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was not posted.

On October 22, 2015, the inspector observed the home's policy entitled 'Prevention of Abuse and Neglect of a Resident #V11-G-10.00' current revision January 2015 was not posted.

An interview with ADOC #107 confirmed the above observation. [s. 79. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive annual training in all the areas required under subsection 76 (7) of the Act.

A review of the training record indicated 54 Per cent of direct care staff did not receive training in mental health issues, including caring for persons with dementia and behaviour management issues in 2014.

Interview with ADOC #107 confirmed that not 100 Per cent direct care staff received training in mental health issues, including caring for persons with dementia and behaviour management issues in 2014. [s. 221. (2)]

Issued on this 12th day of February, 2016

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

Original report signed by the inspector.