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

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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
Feb 14, Mar 10, 2017	2016_328571_0031	013524-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

PATRICIA MATA (571), DENISE BROWN (626), KELLY BURNS (554), SARAH GILLIS (623)

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): The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 7, 8, 9, 10, 14, 15, 16, 17 and 18, 2016

The following were inspected during the course of the Resident Quality Inspection:

1. Critical Incident Logs

Intake Log #029104-16: Related to fall
Intake Log #024135-16: Related to resident to resident abuse
Intake Log #027049-16: Related to staff to resident abuse

2. Follow-up Intake Logs

Intake Log #027525-16: Related to CO #001, s. 6. (7)
Intake Log #027559-16: Related to CO #001, s. 6. (10)

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI Coordinator-Staff Educator, Environmental Services Manager (EMS), Registered Dietitian, Activity Manager, Office Manager, Food Service Manager, Nursing Scheduling Clerk , Registered Nurses (RN), Registered Practical Nurses (RPN), Behaviour Support Team (BSO), Personal Support Workers (PSW), Physiotherapy Assistant, House Keeping Aide, Restorative Aides, Activity Aide, Maintenance Staff, Family and Resident Council Presidents, Residents and Family Members.

During the inspection, the inspector (s), toured the resident home areas, observed staff to resident provision of care, resident to resident interactions, infection control practices and medication administration. The inspectors reviewed residents health records, internal related investigations, maintenance records, applicable policies, Resident and Family Council minutes and critical incidents.

The following policies were reviewed:

Falls Prevention, Prevention of Abuse and Neglect of a Resident, Skin and Wound Care Management, Medication Administration, Responsive Behaviours, Weight Change Program, Routine/ Standard Precautions, Housekeeping Job Routine, Hand Hygiene, Common Area Job Routine, Monthly Deep Cleans, Responsive Behaviours, Zero Tolerance of Abuse , Nail Care - Hands, Personal Hygiene / Grooming and Dressing Attire.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **17 WN(s)**
- **11 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. 6. (10)	CO #001	2016_461552_0020	571
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_461552_0021	626

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

s. 6. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

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, related to falls risks.

Related to Intake Log #029104-16 which involved resident #047:

A Critical Incident Report was submitted to the Director on a specified date, pertaining to the resident's fall which resulted in a transfer to hospital and the diagnosis of an injury. The resident fell on a specified date and was sent to hospital after the fall. Resident #047 returned to the home on same day and died a few days after returning to the home. The resident began using a specified device for mobility following a fall on a specified date,

previous to the most recent fall in which the resident sustained an injury. The current care plan did not provide clear direction to staff because it did not indicate that resident #047 was using a specified mobility device, at the time of the most recent fall.

The progress notes indicated that staff was alerted by an alarm on a specified date and found the resident #047, lying on the floor beside the bed. The resident had multiple falls before the most recent fall.

According to the care plan for resident #047, had nine fall prevention interventions in place, at the time of the most recent fall.

On review of the resident's health records, documentation was found in the progress note to indicate that on three occasions on a specified date, the resident required use of a specified mobility device, in order to be transported to the dining room. A review of the resident's care plan indicated that on the same specified date a consultation request was made for Physiotherapy and Occupational therapy, to determine an appropriate mobility aid. The Physiotherapy Progress Notes indicated, that the resident was no longer able to stand independently, while walking with assistance and had to be immediately seated in a mobility device. The progress note entry on a specified date, indicated that a consultant had planned to visit the home to perform an assessment for the resident. Progress note entry on another specified date, also indicated that resident #047 had been using a specified device for mobility but this information was not noted in the care plan. The resident had previously ambulated using mobility device and began using the specified device for mobility before the most recent fall.

During an interview in November 2016 with Nursing Aide #144, the staff indicated that the resident used a device for mobility. In another interview in November 2016, RPN #145 indicated that the resident was previously using a device for mobility but was using the specified mobility device at the time of the most recent fall. The DOC indicated in November 2016, that the resident was previously using another device for mobility before a previous fall and after this particular fall began the specified mobility device. In the same interview, the DOC confirmed that the use of the specified mobility device by resident #047 was not indicated in the care plan.

The plan of care for resident #047 did not provide clear direction to staff because it did not indicate that the resident was using the specified device for mobility. [s. 6. (1) (c)]

2. Related to resident #033:

Resident #033 was admitted to the home in 2016. The resident had one fall while in the home and was noted to be at high risk for falls on admission. According to the progress notes on a specified date, a day after the resident's admission to the home, a falls prevention intervention was applied at the SDM's request. In November 2016, resident #033 was observed with out the application of the falls prevention device, as indicated in the plan of care.

A review of resident #033 health records pertaining to the current care plan in November 2016, indicated that the resident was at high risk for falls, related to previous history of falls before admission and medical history. Progress notes indicated that on specified date, the falls prevention device was removed at the SDM's request and that the resident did not have any falls since admission. The health records indicated that the resident fell on specified date in 2016. In a review of the resident's health records, the documentation in the care plan, indicated that the falls prevention devices were to be in place. In November 2016, inspector #626 observed resident #033 sitting in the a mobility device and there was falls prevention devices in place. In further observation on the same day of the resident's bed and no falls prevention device was found to be in place.

During an interview in November 2016, RPN #131 indicated that the resident is to have a fall falls prevention device in place. In an interview in November 2016, PSW #133 indicated that the resident used another falls prevention device but did not use any other equipment for falls prevention. In another interview in November 2016, PSW #132 indicated that there was no equipment in place to prevent falls for resident #033.

In an interview with the DOC in November 15, 2016, the DOC indicated that the resident was at high risk for falls on admission but was considered at low risk when the interview was conducted. In the same interview, the DOC indicated that on a specified date in November 2016, after an inquiry was made by inspector #626 regarding the resident's fall prevention interventions, staff informed the DOC that there were no falls prevention interventions in place. During the same interview in November 2016, the DOC also indicated that instructions were given by the DOC to implement these interventions. The DOC also confirmed, that the falls prevention devices were noted in the current plan of care. In November 2016, after the interview with inspector #626, a progress note entry was made by the DOC indicating that the SDM did not want a specific falls prevention device applied but agreed to have other devices in place.

The care set out in the plan of care did not provide clear direction, pertaining to the use

of falls prevention interventions for resident #033 such as the falls prevention devices specified in the plan. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care is based on the resident's needs and preferences related to bathing.

Related to resident #037:

Resident #037 is cognitively well and able to advocate for his or herself.

During an interview with Inspector #623 in November 2016, resident #037 indicated a preference of more than two baths a week. Resident #037 indicated being asked on admission, in regards to having two baths a week but was never offered the choice to have more. Resident #037 indicated that in the past, when the request was made for additional baths, the response by staff was that it was considered luck to receive the current number of baths. The resident was unable to identify the staff have who made the comment about being lucky to get more baths. Resident #037 indicated an understanding that the request for additional bathing would be granted, if ordered by the doctor. Resident #037 indicated that a preference to have more than two baths a week and an additional bath any time of the day or any day of the week .

Resident #037 also indicated a preference to have a bath instead of a shower. The resident is currently scheduled for a bath on two specific days of the week currently to receive a bath. Resident indicated that having a sponge bath every morning in the bathroom sink provides a feeling of being clean. The resident also indicated, that the sponge bath is done independently but often has to wait a long time to use the bathroom because it is shared with other residents.

Review of the admission records for resident #037 completed in 2014, indicated a Bathing survey which was signed by resident #037. Question: Is it your wish to receive a second scheduled bath, shower or bed bath in a week? Yes or No. Resident signed as "yes" for the answer.

The bathing survey had an area at the bottom of the sheet for preferences which was to be signed quarterly with the reviewed. This area was blank and did not indicate that resident #037's bathing preferences were reviewed quarterly after admission. There were no further assessments or reference to resident bathing preferences being reviewed at the annual care conference in the electronic or paper chart. Review of the plan of care

identified bathing with limited assistance, resident enjoys a tub bath, staff to provide a partial sponge bath every morning and evening. There have been no changes to the bathing section of the care plan since 2015.

During an interview in November 2016, RAI#105 indicated that two baths a week was "Ministry Standard". If a resident wants more than two baths a week, direction was provided to hire an agency at the resident's own expense, to provide any additional baths. RAI#105 indicated, that if a resident could walk to the shower and bathe independently, then the resident would not require supervision. If the resident wish an additional bath, then this would be an additional service. RAI#105 was unsure of what would be available to a resident that could not afford to pay for an additional bath per week but preferred to have one or was assessed as needing one. RAI#105 was not aware of anyone that was requesting this but believes that it would be addressed, should the situation arise. RAI#105 was not aware that resident #037 would prefer more than two baths a week.

During an interview PSW #106 indicated, that residents are bathed according to the schedule. The PSW also indicated not being sure what would happen, if a resident requested more baths than what was scheduled.

Therefore the licensee failed to ensure that the plan of care for resident #037 is based on the resident's needs and preferences related to bathing. [s. 6. (2)]

4. The licensee failed ensure that the care set out in the plan of care was provided to the resident as specified in the plan specific to falls for resident #047.

Related to Intake Log #029104-16 which involved resident #047:

A Critical Incident Report was submitted to the Director on a specified date, pertaining to the resident's fall, which resulted in a transfer to hospital and the diagnosis of an injury. The resident fell on a specified date, was sent to hospital and returned to the home on the same day. Resident #047 died a few days after returning to the home from the hospital. Resident #047 was not wearing the falls prevention device as indicated in the plan of care, at the time of the most recent fall.

The progress notes indicated that staff was alerted by the bed alarm on a specified date and found the resident #047, lying on the floor beside the bed. The resident had multiple falls before the most recent fall. According to the care plan, there were nine falls

prevention interventions in place, at the time of the most recent fall.

In an interview in November 2016, PSW #144 who was on duty at the time of the incident, could not recall the falls prevention measures were in place for the resident when the most recent fall occurred. In another interview RPN #145 who was also on duty when the incident occurred, indicated that resident #047 was not wearing the falls prevention device specified, at the time of the most recent fall. The investigation notes provided by the DOC pertaining to the most recent fall, indicated that the resident was not wearing a falls prevention device, at the time of the fall. During an interview in November 2016, the DOC confirmed that the resident was not wearing the falls prevention device, at the time of the fall.

The care set out in the plan of care was not provided to the resident as specified in the plan, as resident #047's falls prevention device was not applied.

At the time of this inspection, there was an outstanding compliance order (CO #001) specific to LTCHA, 2007, s. 6 (7), issued under inspection report #2016_461552_0021 with a compliance date of September 30, 2016. The incident, identified above occurred before the order compliance due date. [s. 6. (7)]

5. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, specific to responsive behaviours of resident #044 and the safe guarding of co-residents.

Related to intake #024135-16, for resident #044:

Resident #044 has a medical diagnosis which includes cognitive impairment.

Registered Practical Nurse #122, PSW #123, DOC and the Administrator (ADM) indicated, to the inspector, that resident #044 exhibits responsive behaviours, specifically related to physical aggression, directed towards co-residents and staff.

The Director of Care and the Administrator indicated (to the inspector) that resident #044's plan of care included one to one staffing, due to aggression and to ensure the safety of other residents.

Personal Support Worker #123 and #124, RPN #115, and RN #104 all indicated (to the inspector) that one to one staffing was an intervention that was being used for resident

#044.

The clinical health record, specifically the progress notes, for resident #044 details the following:

-On a specified date, resident #044 exited the room, after the assigned one to one care provider went on break. After leaving the room resident #044 walked towards co-resident #049 and ran over resident #049's feet with the walker. A Registered Practical Nurse and a visitor attempted to redirect resident #044, who became resistive and proceeded to use the walker to hit the RPN. The visitor immediately proceeded to get more help.

The Director of Care and the Administrator indicated that the one to one care provider should have had another staff relieve him or her before departing for break.

Personal Support Worker #123 and #124, as well as RPN #115 indicated, that it is an expectation that the one to one staff assigned to care for resident #044, was to be relieved by another personal support worker or registered nursing staff before departing for breaks. All staff that were interviewed indicated that resident was not to be left unattended due to resident's unpredictable aggression.

At the time of this inspection, there was an outstanding compliance order (CO #001) specific to LTCHA, 2007, s. 6 (7), issued under inspection report #2016_461552_0021 with a compliance due date of September 30, 2016. The incident identified above occurred prior to the compliance due date. [s. 6. (7)]

6.The licensee has failed to ensure that the resident was reassessed and the plan of care revised, when care set out in the plan had not been effective and different approaches were not considered, related to falls risk.

Related to resident #016:

Resident #016 was admitted to the home on a specified date in 2016. Resident #016 also has a history of responsive behaviours. The resident has had multiple falls in 2016 and was at high risk for falls. On a specified date in November 2016 resident #016 was observed by Inspector #626 sitting in a a mobility device and did not have a falls prevention device in place, as indicated in the plan of care.

A review of resident #016 health records indicated that the resident had eight falls

prevention interventions in place.

During an interview in November 2016, RPN #112 indicated, that the falls prevention device could have been discontinued and also confirmed that the device was noted on the care plan. Register Practical Nurse #112 also indicated, that an inquiry would be made to determine if the device was discontinued and if so, it will be removed from the care plan. In another interview in November 2016, PSW #129 indicated that the resident was disturbed by the sound of the falls prevention device and would discard the item in the garbage. During an interview in November 2016, PSW #142, also indicated that the device was not used as the resident would remove the device and throw the item away. In an interview in November 2016, the DOC indicated that resident #016 is at high risk for falls and the device was a falls prevention measure.

The licensee has failed to ensure that the resident was reassessed and the plan of care revised when care set out in the plan had not been effective. Different approaches were not considered as resident #016 was at high risk for falls and would not keep the falls prevention device on the mobility aid. [s. 6. (11) (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 the following provisions in regards to the plan of care: that the plan of care set out clear directions to staff and others who provide direct care to residents; that it is based on an assessment of the resident and the needs and preferences of that resident; that the care set out in the plan of care is provided to the resident as specified in the plan, related to resident #016, #033, #037, #044, #047, to be implemented voluntarily.

WN #2: 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 LTCHA 2007, s. 11. (1) (a), directs the licensee to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. O. Reg. 79/10, s. 68. (2) directs that this program should include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

The licensee's policy #RESI-05-02-07 version November 2013 entitled "Weight Change Program" indicated that the registered staff are to compare the previous month's weight and any weight difference of 2.5 kg from the previous month requires a re-weigh. Registered staff are to direct the direct care staff to re-weigh the resident.

The licensee failed to insure that their policy #RESI-05-02-07 version November 2013 entitled "Weight Change Program" was complied with for resident #002, #017 and #033.

Related to resident #002:

A review of the weight record in the licensee's electronic documentation for resident #002 and the "Resident Weight Monitoring" documentation sheet indicated a change in body weights that exceeded 2.5 kg over three consecutive identified months in 2016.

RPN #112 indicated in an interview with Inspector #571 in November 2016, that a resident should be reweighed, if there is a weight difference of three kilograms. No evidence of reweighs could be found.

Related to resident #017:

A review of the weight record in the licensee's electronic documentation and Resident Weight Monitoring documentation sheet for resident #017 indicated a change in body weights that exceeded 2.5 kg over five consecutive identified months in 2016.

RPN #113 indicated in an interview in November 2016 with Inspector #571, that staff should reweigh a resident if there is more than 2.2 kg weight difference. No evidence of reweighs for resident #017 could be found.

Related to resident #033:

A review of the weight record in the licensee's electronic documentation and Resident Weight Monitoring documentation sheet for resident #033 indicated a change in body weights that exceeded 2.5 kg over three consecutive identified months in 2016.

A review of the progress notes indicated that in August 2016, under the heading Dietary Quarterly Summary, the RD documented that the June weight appears to be incorrect at 56.7 Kg but the resident wasn't re-weighed.

In an interview in November 2016 with PSW #116, the PSW indicated that if residents need to be reweighed, the registered staff would provide give the PSWs with a list of residents who require reweighs. These reweighs are to be completed within several days of the previous weight. No evidence of a reweigh could be found.

Therefore, the licensee failed to ensure their weight change policy was complied with for resident #002, #017 and #033. [s. 8. (1) (a),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 here is a process in place and monitored in order to safeguard that any plan, policy, protocol, procedure and strategy in place is complied with, specific to an organized program of nutrition care and dietary services to meet the daily nutrition needs of the residents, specifically addressing weight changes, related to resident #002, #017, #033, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1.On a specified date in November 2016, the janitor room, located on the second floor resident home area was observed (by an Inspector) open and unattended by staff.

The janitor's room was observed (by the Inspector) to contain, a housekeeping cart with cleaning agents on top of the cart; chemicals observed on top of the housekeeping cart.

Personal Support Worker #100 indicated, to the Inspector, that the janitor's room was not to be left unlocked, and that the room was not to be accessible to residents. PSW #100 closed the janitor room door.

Housekeeping Aid (HSK) #101 returned to the janitor's room at approximately twenty-five minutes after the door was initially observed opened; HSK #101 indicated, to the Inspector, that the door was left opened, while resident's were being portered to the

dining room. HSK #101 indicated the janitor's room is a non-residential area and is not to be left unlocked or unsupervised by staff. [s. 9. (1) 2.]

2.The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On a specified date in November 2016, during the initial tour of the home, the Inspector noted the following:

-One of the two laundry chute doors was ajar, the door was not locked. The laundry chute door identified as being ajar was located on a resident home area, which is a resident home area, within the long-term care home.

Residents were observed sitting within close proximity of the laundry chute door. There were no staff observed within the area at the time of this observation.

Registered Nurse #104 indicated (to the Inspector) the laundry chute door is to be locked at all times. RN #104 indicated the laundry chute is considered a non-residential area.

Environmental Services Manager indicated being unaware that the door to the laundry chute was not locking; ESM indicated he or she was new to his role and further indicated that he or she would have the door fixed right away.

During further observations, mid-afternoon on a specified date in November 2016, Inspector #623, observed the third floor laundry chute door ajar; the Inspector indicated the key to the door was stuck inside the door, preventing the door from closing.

Residents were observed sitting within close proximity of the laundry chute door.

Registered Nurse #104 indicated not being aware that the laundry chute door was not being properly closed or locked. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored in order to safeguard that doors leading to non-resident areas are locked when not supervised by staff, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's cleaning procedures for the housekeeping departments, specifically Monthly Deep Cleans and Common Area Job Routine indicate the following:

-Common Area Job Routine - for a specified resident home areas, direct that cleaning will consist of common areas, including shower rooms - cleans will include, checking walls, and ledges for soiling; clean as required; spot clean windows as required; spot wash floor surfaces, getting behind and into corners.
-Monthly Deep Clean Duties - for week #1 - a specified resident home area tub and shower room are to be deep cleaned; this clean includes the walls, floors, ceilings, handrails and windows; In a specified resident home area the tub-shower room is scheduled for Tuesday of week #1 and and in another resident home area the tub-

shower room is scheduled for Thursday of week #1.

The following was observed on six separate days in November 2016:

-Shower Stall - dark brown staining and debris was observed along the caulking and wall/flooring edges in the shower stall. This shower was located on a resident home area and was in use for resident care. This was also observed in the shower stall of another resident home area.
-Windows - dark brown debris, stringy substance and dead insects were observed on windows and on existing screens in lounges in two separate home areas and in tub-shower rooms on the same resident home areas.
-Fan - a wall mounted fan, which blows directly towards the tub, in two separate home areas, tub rooms, were observed to have dark greyish stringy substance on the fan's metal screen. This fan was observed in operation on four consecutive dates in November 2016. Fans mounted in the hallway, outside of resident rooms were also noted to have dark greyish substance on the fan's metal screening; these fans were in operations during this inspection.
-Bath Chairs - were observed to have whitish film on the seating and underside of the chair. This bath chair was observed in the tub rooms on two resident home areas and were in use for bathing of residents.
-ARJO Tub - the plastic face plate of the tub (encompasses faucet, taps and operational buttons) was observed to be covered with a whitish film and having brownish substance along facing edges. This tub is located in the tub room on a specified resident care area. This tub is being regularly used for bathing residents.
-Toilet - dark brown staining was observed along the flooring and base of the toilet stool; this toilet was located in the tub-shower room on a specified resident care area.

Personal Support Workers #106 and #124, as well as, RN #104, who is the lead for the Infection Prevention and Control Program, indicated tubs and bath chairs are to be cleaned and disinfected following resident use.

Personal Support Worker (PSW) #124 indicated a disinfectant is used on the bath chair; the disinfectant is sprayed on to the bath chair and then it is sprayed; occasionally a scrub-brush is used to scrub the bath chair but the brush isn't always available, so then the disinfectant is just rinsed off, and the chair is not scrubbed. PSW #124 indicated the inside of the tub is sprayed with disinfectant, but the faceplate (front panel) of the tub where the buttons (for operation) are located is not cleaned by personal support workers. PSW #124 indicated that housekeeping staff should clean the faceplate on the tub.

Food Service Manager (FSM), whose role included the housekeeping department up until three weeks ago, indicated both housekeepers should be scrubbing along wall-flooring edges within the shower stalls and tub room as part of their cleaning procedures; windows and fans within the tub room should be cleaned as well. FSM indicated there is nothing in the cleaning routines to direct housekeepers to specifically clean the actual tub facing (faceplate). It was the belief of FSM that the tub facing may be an area that is being missed by both nursing and housekeeping when cleaning the tub and or shower area.

Food Services Manager indicated it would be an expectation that the home is kept clean and sanitary.

The Environmental Services Manager was not available for interview for four consecutive days in November 2016. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made, during dates of this inspection:

-Walls - observed to be gouged and or having paint peeling from walls in resident in four residents' rooms; as well as the communal resident washroom located on a specified resident home area; wall at the corner of a specified work area and area entering utility rooms was observed to be chipped with corner steel beading exposed;

-Door and door frames - observed to have paint chipped and areas of visible rust on the door/door frame, involving nine residents' rooms; as well as in the tub room located on a specified resident home area;

-Floors - tiles observed to be lifting in areas, in a specified resident's room;

-Counter-top vanity - laminate surround observed missing (side facing the toilet) in six residents' washrooms; areas with missing laminate was observed porous in nature;

-Drain - the drain inside the sink, was observed to have the finish missing or areas rusted, in three resident's washrooms;

-Grab bars - observed rusted or having corrosion in the communal washroom (near tub room) in a specified resident home area, and in the shower room, located on another resident home;

-Over toilet, Toileting Seat/Frame - was observed rusted in a specified shared residents' washroom;

-Ceiling - the stucco ceiling within a resident's room and in two other resident's washrooms were observed to have yellowish-brown staining;

-Ceramic Tiles - observed to be chipped or missing on walls in three residents' washrooms;

-Flooring - laminate flooring in a specified resident home area was observed to be cracked and lifting in areas adjacent to the tub; the floor was observed wet, with water seeping onto the exposed sub-flooring and noted to be cracked or chipped near threshold or entrance to another resident home area;

-Foot and or Head Boards - were observed to be gouged or having the laminate surround missing, in two residents' rooms, these were porous in nature;

-Nursing Station - laminate counter surround, in a specified resident home area was observed chipped and or missing in areas, facing resident lounge, this surface was porous in nature;

-Baseboard Heater - in a specified resident home area the baseboard heater in the tub shower room was observed to be rusted;

-Wing-Back Chairs - the wooden legs of the chairs (owned by the home) were observed to have the shellac finishing worn, and or chipped; these chairs were located in lounges located on two specified resident home areas;

-Tubs - the blue rubber tub surround was observed to be missing or loose in two separate resident care areas;

-Walls - observed damaged (having holes, exposed dry wall or plaster walls, steel corner beading exposed) in the tub rooms located on two specified resident care areas;

-Wall Guard - observed to be chipped and or cracked with jagged edges in a specified resident care area; as well as outside of the dining room on another resident home area;

-Elevators (on a specified floor) - tiled flooring within the elevator was observed cracked;

-Water Dispenser - located in the dining room, on Island House was observed rusted along the base of the water dispensing unit;

-Flooring - tiled or concrete areas around floor drains or access areas were observed chipped and or uneven; this flooring was observed on the main floor of the long-term care home.

The Maintenance Request Logs (binders) for two separate home areas were reviewed (by the Inspector) pertaining to a period of two to three months during 2016 and the identified maintenance repairs noted above were not identified in these records.

The Maintenance Staff indicated he was not aware of the areas, identified by the Inspector, as needing repair and or maintenance. Maintenance Staff indicated all staff are responsible for identifying needed repairs and completing the maintenance request log, so that repairs can be quickly addressed. Maintenance Staff indicated that the long-term care home is an older building requiring regular repairs but the above were not identified by staff as needed repairs.

The Environmental Services Manager was unavailable for interview during the week of November 14, to November 18, 2016. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored in order to safeguard that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than fifteen centimetres.

On a specified date in November 2016, an Inspector, observed the following:

-Three windows in a resident lounge, located on a specified resident home area of the long-term care home were observed open and had no screens. The windows could be opened seventeen centimetres.
-Two windows in a resident lounge, located on another specified resident home area of the long-term care home were observed open and had no screens. The windows could be opened seventeen centimetres.

Residents were observed to be sitting in the identified lounges.

The Maintenance Staff #147 and Environmental Services Manager were not aware that the windows opened beyond the fifteen centimetres.

The Environmental Services Manager indicated (to the Inspector) that by end of the business day on the day that it was identified, the windows were fixed and were in keeping with legislative requirements. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored in order to safeguard that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: 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 a resident-staff communication and response system is available in every area accessible by residents.

On a specified date in November 2016, during the initial tour of the long-term care home, an Inspector, observed that there was no resident-staff communication and response system in an area that was accessible to resident.

Restorative Care Aid #102 indicated (to the Inspector) that the room is resident accessible area and is used by residents.

Restorative Care Aid #102 and the Physiotherapy Assistant (PTA) #103 confirmed that the room does not have a resident-staff communication and response system nor does the adjacent room. PTA further indicated that there is no phone in the adjacent room should staff or a resident require assistance.

The Environmental Services Manager was not aware that the two rooms did not have a resident-staff communication and response system. [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 to ensure that a resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #7: 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 failed to ensure that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, had occurred or may occur, immediately report the suspicion and information upon which it was based to the Director.

Related to Intake #027049-16, for resident #045:

The Director of Care submitted a Critical Incident Report to the Director, on a specified date, regarding an alleged incident of staff to resident abuse, which was said to have occurred on one day before the CIR was submitted.

The Director of Care indicated being first aware of the alleged staff to resident abuse on a specified date, when a letter from AA #117 was found on the DOC's desk.

The statement, written by Activity Aid #117, detailed the following:

-At a specified time on a specified date, Activity Aid (AA)#118 told resident #045 that he or she was taking the resident to an activity program in the sun room on the main floor of the long-term care home; resident #045 resides on another floor in the home. Resident #045 indicated to AA #118, a desire not to attend the activity program. Activity Aid #118 proceeded to take resident #045 to the activity program, after the resident had indicated a desire not to attend. Activity Aid #117 indicated, that resident #045 was upset and left

the activity program.

Activity Aid #117 indicated in a written statement, that the Office Manager overheard the altercation between resident #045 and AA #118 and, directed AA #117 to report the incident to the nurse on duty. Activity Aid #117 further indicated, in a statement, that the incident was reported to RN #121, who was the unit Charge Nurse and that RN #121 gave direction to report the incident to RN #120, who was the supervisor on duty.

Activity Aid #117 indicated that RN #120 contacted the Director of Care by phone and direction was given, that AA #117 to document the alleged witnessed incident. The DOC also indicated that the alleged incident would be reviewed the next day.

During a second interview, the DOC indicated, that the Administrator reminded the DOC that morning of a conversation with RN #120, about the incident on the day that it had occurred. The DOC acknowledged, that the RN#120 was directed to have AA #117 document the incident, which was to be followed-up on the next day.

Administrator and the Director of Care indicated all registered nursing staff, as well as the Office Manager are aware of when to contact Ministry of Health and Long-Term Care to report abuse allegations; RN #120 was spoken to about the incident needing to have been reported earlier, using the after-hours number". Administrator indicated "the abuse allegation should have been reported August 30, 2016. [s. 24. (1)]

2. The licensee failed to ensure a person who had reasonable grounds to suspect that, abuse of a resident by anyone, has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Related to resident #044 and resident #048:

The clinical health record, which included progress notes, specific to resident #044,for a month period were reviewed by the Inspector. Progress notes that were reviewed, provided the details of the following:

-On a specified date, resident #044 was very aggressive towards staff and other residents. Resident #044 continued to be agitated and staff were unable to redirect resident. Resident #048 was sleeping in the bed, when resident #044 smacked resident #048 on a body part. According to the progress note, resident #048 sustained an injury to a body part. It was further indicated in the progress notes, that resident #044 threw coat

hangers at resident #048 before staff were able to direct resident #044 away from resident #048. According to the progress notes, resident #044 continued to wander the halls, going from room to room banging on co-resident's doors.

Registered Practical Nurse (RPN) #161, who was the Unit Charge Nurse and Registered Nurse (RN) #160, who was the Supervisor on duty both were aware of the incident of resident to resident abuse.

The Director of Care indicated of being made aware of the incident of resident to resident abuse on the date of which the incident occurred. Director of Care also indicated being informed by RN #160.

The resident to resident physical abuse incident, which was witnessed, on the specified date was not immediately reported to the Director. At the time of this inspection, the resident to resident abuse had not yet been reported to the Director. [s. 24. (1)]

3. Related to resident #044 and resident #043:

Resident #044 has a medical diagnosis which includes cognitive impairment. Registered Practical Nurse (RPN) #122, Personal Support Worker (PSW) #123, Director of Care (DOC) and the Administrator (ADM) indicated, to the Inspector, that resident #044 exhibits responsive behaviours, specifically physical aggression directed towards co-residents and staff.

The clinical health record, which included progress notes, specific to resident #044, were reviewed for a one month period by the inspector. Progress notes reviewed, provided the following details:

-on a specified - Resident #043 reported to PSW #124 of being grabbed on the previous day by co-resident #044. Resident #043 indicated that resident #044 squeezed a body part of resident #43. Resident #043 indicated that there was an injury to the body part, as a result of being grabbed by resident #044. As documented in the identified progress note, resident #043 had sustained an injury to a body part. The incident was reported by PSW #124 to the Director of Care.

The Director of Care indicated (to the inspector) being aware of the incident, which was reported on a specified date when the incident occurred. The Director of Care indicated the alleged physical abuse of resident #043 was not reported to the Director. [s. 24. (1)]

4. Related to resident #050

During this inspection, Inspector #571 interviewed resident #053 in November 2016. During the interview, the resident reported that a concern about resident #050. Resident #053, explained that resident #050 does not always eat very much at meals. Resident #050 indicated that at a specified time, a PSW whom resident #053 could not identify, forcefully fed food to resident #050. Resident #053 indicated that resident #050 yelled at the PSW to stop. Resident #053 reported this to management but could not remember exact dates.

A review of the Resident Council meeting minutes indicated that on a specified date, during the resident council meeting, resident #053 expressed concern about a staff member force feeding another resident by holding the resident's hands down.

The Recreation Manager indicated in an interview with Inspector #571 on a specified date in November 2016, that during the resident council meeting on a specified date the incident was reported to the DOC in place at that time.The DOC in place at the time that the incident occurred did not report the incident to the Director (MOHLTC).

In an interview, in November 2016, the Administrator indicated that the alleged staff to resident abuse that occurred which involved resident #050 was not reported to the Director (MOHLTC). A Critical Incident was submitted regarding this incident, after the Administrator was interviewed by Inspector #571.

Therefore, the licensee failed to immediately report the suspicion of alleged staff to resident abuse and the information upon which it was based 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 to ensure that there is a process in place and monitored in order to safeguard that the Director is immediately notified of suspected witnessed or alleged abuse of a resident by anyone, to be implemented voluntarily.

WN #8: 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 residents' personal items are labelled within forty-eight hours of admission and in the case of acquiring new items.

During dates of this inspection, the following were observed in residents' rooms, by inspectors:

- a bar of soap and two toothbrushes were observed on the counter-top vanity, in a washroom shared by four residents. Items were unlabelled.
- an electric toothbrush was observed, on the counter-top vanity; the item was unlabelled. This is a washroom shared by four residents.
- a k-basin, three toothbrushes, two denture cups and a comb were observed, on top of a paper-towel dispenser, in a washroom shared by four residents. Items were all unlabelled.
- two k-basins and a toothbrush were observed on the counter-top vanity; items were unlabelled. This washroom is shared by two residents.
- an electric toothbrush, deodorant, denture cup and another toothbrush were observed on the counter-top vanity, in a washroom shared by two residents. Items were all unlabelled.

Registered Nurse (RN) #104, who is the lead for Infection Prevention and Control indicated to the inspector, all resident care items are to be labelled for individual resident use. RN #104 indicated "resident care items are to be stored in the individual resident's bedside table and not left in washrooms".

Registered Nurse #104 indicated that this is an ongoing concern within the long-term care home and such has been addressed with staff. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored in order to safeguard that each resident's personal items are labelled within forty-eight hours of admission and in the case of acquiring new items, to be implemented voluntarily.

WN #9: 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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to intake #027049-16, for resident #045:

The Director of Care submitted a Critical Incident Report to the Director, on a specified date, regarding an alleged incident of staff to resident physical abuse, which was said to have occurred on the previous day.

There is no documentation in the resident's health care record indicating that, the SDM for resident #045 was notified of the alleged staff to resident physical abuse by the Office Manager, RN #120 or RN #121, during the specified and date.

The Director of Care indicated, to the inspector, that the SDM for resident #045 was not notified of the alleged staff to resident abuse incident one day after the incident had occurred.[s. 97. (1) (a)]

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

Related to resident #048:

The clinical health record, which included progress notes, specific to resident #044,for a month month period were reviewed by the inspector. Progress notes that were reviewed, provided the details of the following:

- On a specified date, resident #044 was very aggressive towards staff and other residents. Resident #044 continued to be agitated and staff were unable to redirect resident. Resident #048 was sleeping in the bed, when resident #044 smacked resident #048 on a body part. According to the progress note, resident #048's sustained an injury on a body part. It was further indicated in the progress notes, that resident #044 threw coat hangers at resident #048 before staff were able to direct resident #044 away from resident #048. According to the progress notes, resident #044 continued to wander the halls, going from room to room banging on co-resident's doors.

The Director of Care indicated in November 2016, that Registered Practical Nurse (RPN) #161, who was the Unit Charge Nurse and Registered Nurse (RN) #160, who was the Supervisor on duty both were aware of the incident of resident to resident abuse. Director of Care further indicated that there was no documentation found in resident's health care record indicating that the substitute decision maker for resident #048 was notified of the witnessed resident to resident physical abuse incident.

The DOC also indicated in November 2016, that registered nursing staff are to notify the

substitute decision maker of resident incidents. [s. 97. (1) (a)]

3. The licensee failed to ensure that that resident's substitute decision maker (SDM) was notified of the results of the alleged abuse or neglect investigation immediately upon completion.

Related to Intake #027049-16, for resident #045:

The Director of Care submitted a Critical Incident Report to the Director, on a specified date, regarding an alleged incident of staff to resident abuse, which was said to have occurred on the previous day.

The Director of Care and the Administrator indicated to the inspector, that the home's investigation concluded on specified date. The Administrator indicated, to the inspector, that Activity Aid (AA) #118 actions on the specified date that the incident occurred were in violation of the Resident's Bill of Rights.

Director of Care indicated, to the inspector, that the SDM for resident #045 was not notified of the results of the home's investigation of the alleged abuse incident. [s. 97. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored in order to safeguard that the resident's substitute decision-maker (SDM) and any other person specified by the resident are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident. The SDM is also to be notified of the results immediately upon the completion of the investigation, related to resident #045 and #048, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training

Specifically failed to comply with the following:

s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff who are at the home pursuant to a contract or agreement with the licensee will not provide direct care to residents before receiving the following information, the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports, whistle-blowing protections under section 26, fire prevention and safety, emergency and evacuation procedure and or infection prevention and control, specifically, hand hygiene, modes of infection transmission, cleaning and disinfection practices; and, use of personal protective equipment.

Under O. Reg. 79/10, s. 222 (1) - Subject to subsection (2), a licensee of a long-term care home is exempt from the requirements under section 76 of the Act with respect to persons who, (a) fall under clause (b) or (c) of the definition of "staff" in subsection 2 (1) of the Act; (b) will only provide occasional maintenance or repair services to the home; and (c) will not provide direct care to residents. (Note: The licensee does not meet the exemption as identified in O. Reg. 79/10, s. 222 (1).

Under LTCHA, 2007, s. 76 (1) - Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

The Administrator, as well as the Director of Care indicated that the licensee contracts registered nursing staff and non-regulated nursing staff to work within the long-term care home.

Registered Nurse (RN) #160 is an agency contracted registered nursing staff who is working at the long-term care home; RN #160 is employed by a nursing agency.

Registered Nurse #160 was the Supervisor on duty on the specified date of the witnessed incident of resident to resident physical abuse was said to have occurred, between resident #044 and #048. The abuse incident was not immediately reported to the Director.

According to the Director of Care, the licensee relies on the nursing agency to provide information and or training, specific to, the Residents' Bill of Rights, duty to make mandatory reports, whistle-blowing protections, fire prevention and safety, emergency and evacuation procedures and infection prevention and control procedures. Director of Care indicated information provided by the agency is not specific to home or its policies and/or procedures.

Director of Care indicated, agency registered nursing staff, specifically RN #160 was not provided information specific to the home's policy to promote zero tolerance of abuse and neglect of residents, prior to commencing direct care with residents residing at the long-term care home. [s. 222. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored in order to safeguard that ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services, to be implemented voluntarily.

WN #11: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

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

The home's policy, Routine/Standard Precautions (#IC-02-01-01), which is part of the long-term care home's Infection Control Program, states that everyone in the home continually practices routine precautions to prevent the spread of infections.

The policy directs the following:
- Hand Hygiene - practice thorough washing and or sanitizing of hands before and after direct resident contact, when handling soiled articles and as required. In addition, use alcohol based hand sanitizer that must be readily available for all staff.
- Barrier Precautions - use additional barrier precautions to minimize the risk of exposure to blood, bodily fluids, secretions, excretions, non-intact skin or mucus membranes.
- Gloves - wear gloves if there is a risk of hand contact with bodily fluids, blood, secretions, excretions, non-intact skin or mucus membranes.

The Housekeeping Job Routines direct the following:
- Commencement of shift; obtain all necessary equipment to perform work. Equipment includes gloves.
- Precautions - empty waste receptacles directly into the garbage bag without handling the contents. In the event of any waste that may fall on the floor, be sure to wear gloves when picking it up.
- Always use personal protective equipment.

On a specified date in November 2016, Housekeeping Aid (HSKA) #128 was observed, by an inspector:

- Entering a communal washroom, on the main floor, of the long-term care home, and exited the same washroom carrying a waste receptacle, filled with garbage (paper towels and other debris); HSKA #128 was observed emptying the waste receptacle into the waste receptacle (bag) on her housekeeping cart using her hands to remove the contents. Some of the contents of the waste receptacle spilled onto the floor beside the housekeeping cart; HSKA #128 picked up the garbage which had spilled and placed into waste receptacle on housekeeping cart. HSKA #128 was not observed wearing gloves and did not perform hand hygiene following emptying the garbage.
- HSKA #128 was observed re-entering the communal washroom (as above) carrying a toilet brush and a bottle of toilet bowl cleaner; minutes later, HSKA #128 exited the communal washroom and placed toilet bowl brush and bottle of toilet bowl cleaner on the housekeeping care. HSKA #128 was not observed wearing gloves, or performing hand hygiene following this procedure.
- HSKA #128 re-entered communal washroom (as above) with cleaning cloths; minutes later exited the washroom and proceed with housekeeping cart to Education Conference Room, emptied garbage receptacle in this room and proceeded down main floor hallway. HSKA #128 was not observed wearing gloves or performing hand hygiene.

Housekeeping Aid #128 indicated that she normally performs hand hygiene using the AHBR (alcohol based hand rub) provided for use on the wall in hallways throughout the home. HSKA #128 indicated, that she must have forgotten to perform hand hygiene when inspector observed her that morning. HSKA #128 indicated housekeeping cart is to contain a box of gloves, and she must have forgotten to put a box on her cart that morning.

Registered Nurse (RN) #104, who is the lead for Infection Control, indicated it is the expectation that all staff participate in the Infection Prevention and Control Program which would include hand hygiene and use of personal protective equipment, as per the long-term care home's Infection Control Program and policy. [s. 229. (4)]

2. The home's policy, Cleaning and Disinfecting Equipment (#IC-03-01-07) directs that registered staff and care staff are responsible for cleaning and disinfecting resident care equipment in between resident use. Resident care equipment that is shared amongst residents must be properly cleaned and disinfected after use or when visibly soiled with bodily fluids to prevent the spread of infection. The policy further directs that single-use resident equipment is to be labelled with the resident's name and direct care staff are to use this equipment for residents for which it is labelled.

During dates of this inspection, the following were observed in residents' rooms, by inspectors:

- a urinal was observed on the back of the toilet; the urinal was unlabelled and contained an unidentified fluid. This washroom is a shared washroom and also further adjoins to a another room
- a bedpan was observed on the back of the toilet; the bedpan was unlabelled and contained a dried substance along its inside edges. This washroom is shared by four residents.
- unlabelled bedpan was observed sitting inside an unlabelled basin on the floor in the washroom; the bedpan contained a dried brown substance along the inside edges. This washroom is a shared with an adjoining resident room.
- a basin was observed on the floor under the sink, and a used urine collection device (hat) was observed on the back of the toilet, both items were unlabelled. This washroom is a shared by residents.
- a basin was observed on the floor under the sink; the item was unlabelled. This washroom is shared by residents
- a bedpan was observed on the back of the toilet; the item was unlabelled. This washroom is shared by residents.

Registered Nurse (RN) #104, who is the lead for the Infection Prevention and Control Program, and Personal Support Worker #124 indicated, to the inspector, that basins,bedpans and urinals are to be cleaned by care staff following use. Basins are to be labelled for individual resident use and stored in resident's bedside tables, not in washrooms. Bedpans and urinals are to be cleaned following use and stored in the utility rooms, not in resident washrooms.

Registered Nurse #104 indicated being aware that bedpans, urinals and basins are not being stored by care staff as per the long-term care homes policy and procedures. RN #104 indicated that Personal Support Workers have been reminded to clean care equipment (bedpans, urinals and basins) following use and to store under bedside tables and or in utility rooms. RN #104 indicated that as the Infection Control Lead continues to monitor and redirect staff as required. [s. 229. (4)]

3. The licensee failed to ensure that the hand hygiene program is in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, and with access to point of care hand hygiene agents.

Registered Nurse (RN) #104, who is the lead for the home's Infection Prevention and Control Program, indicated, to the inspector, that the long-term care home follows PIDAC (Provincial Infectious Disease Advisory Committee) best practice documents, as well as "Just Clean Your Hands" program for long-term care.

The licensee's policy, Hand Hygiene (IC-02-01-07) acknowledges that the home participates in provincial and or national hand hygiene programs, such as "STOP! Clean Your Hands" (Canada's Hand Hygiene Program) and "Just Clean Your Hands" (Long Term Care for Ontario, Hand Hygiene Program).

The PIDAC, document, directs that alcohol-based hand rub is the preferred method for decontaminating hands. Using alcohol-based hand rub is better than washing hands (even with an antibacterial soap) when hands are not visibly soiled. The practice document further states, for maximum compliance and use, health care providers should perform hand hygiene at the appropriate moment of care. ABHR should be located at point-of-care, i.e., the place where three elements occur together: the client/patient/resident, the health care provider and care or treatment involving client/patient/resident contact. Point-of-care products should be accessible without leaving the client/patient/resident. Installing ABHR dispensers at the point-of-care improves adherence to hand hygiene.

The "Just Clean Your Hands" (JYCH) hand hygiene program directs that providing Alcohol-Based Hand Rub (ABHR) at the point of care makes it easier for staff to clean their hands, the right way at the right time. Alcohol-Based Hand Rub dispensers are to be placed within an arm's reach of where care is provided to residents. The JCYH hand hygiene program indicates that determining the right place for placement of ABHR will differ by unit, resident population group and facility (home) design. The document provide tools, specifically a Placement Checklist, to help long-term care staff and management identify the best location for placement of ABHR.

The Placement Checklist (JCYH's Tool) directs that the long-term care home should conduct a local risk assessment (page three, point #4) related to ABHR dispensers in resident care areas. Care should be taken for residents who are not mentality capable of realizing the negative effects of ingestion and or misuse of the ABHR. Care should include:
- Resident population
- Dispensers protruding in ways that could cause injury
- Product leakage on surfaces that may result in falls or injuries

- Personal carry (ABHR) as an option

During the dates of this inspection (on four consecutive days in November 2016), ABHR dispensers (point of care) were not observed in the following resident rooms, on resident home areas:
- In specified resident home area: six resident rooms
- In a specified resident home area - sixteen rooms
- In s specified resident home area - twelve of the sixteen rooms on this resident home area

During an initial interview, the Infection Prevention and Control Lead, RN #104 indicated being unaware of the reason why resident rooms on Simcoe and Scugog House did not have point of care ABHR dispensers available.

Registered Nurse (RN) #104, indicated she believed ABHR point of care dispensers had not been installed on the secured resident home area (Dymond House, secured unit) due to the potential of cognitively impaired residents ingesting the contents. RN #104 indicated cognitively impaired residents do reside on other resident home areas of which resident rooms do have ABHR dispensers in resident rooms. RN #104 indicated, that she was unsure exactly why Dymond House did not have ABHR dispensers in resident rooms, but further indicated, it was her understanding that staff, working on Dymond House, carry a personal supply of ABHR on their person or in their resident care caddy.

Personal Support Workers #111, and 127, as well as Registered Practical Nurse (RPN) #113, who all work on a resident home area, indicated they do not carry ABHR on their person or in care caddies. Both PSWs indicated that following resident care, they would remove their gloves in the resident's rooms then walk outside the resident's room to cleanse their hands, as such is the closest ABHR dispensers available.

During a subsequent interview, RN #104, indicated (to the Inspector) having had spoken to Food Service Manager, as to reason why resident rooms on two separate resident care areas did not have point of care ABHR dispensers available; RN #104 indicated the Food Service Manager, who oversaw environmental services up until three weeks ago stated the long-term care home ran out of ABHR dispensers during a specified date in 2016, when the long-term care home was implementing the ABHR dispensers, but since the ABHR dispensers had arrived but had not yet been installed. Registered Nurse #104 further indicated being unaware that direct care staff were not carrying ABHR as a personal option in resident care areas where ABHR dispensers were not available.

RN #104 indicated to the Inspector, that having hand hygiene agents accessible at point-of-care is best practice when following the Just Clean Your Hands hand hygiene program. [s. 229. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process in place and monitored in order to safeguard that all staff participate in the infection control program, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted, specifically, the right to be afforded privacy in treatment and in caring for his or her personal care needs.

On a specified date in November 2016, the door to resident #055's room was open, the resident exited the room, leaving the door to the room open and the room visible to the hallway. During this observation, the Inspector observed resident #056 lying on the bed inside the room. Resident #056 was without clothing from the waist up.

Personal Support Worker (PSW) #148 was observed in the room, standing at the end of resident #056 bed. The PSW saw the inspector and closed the door to room.

Upon exit, Personal Support Worker #148 indicated (to the Inspector) an awareness of the requirement to pull privacy curtains during care. PSW #148 indicated that the privacy curtains is not usually used for resident #056, as the resident doesn't like enclosed areas. The information pertaining to the use of the privacy curtains was not noted in resident #056's plan of care.

Resident #056 was unavailable for an interview.

Registered Nurse (RN) #104 indicated (to the Inspector) that routine resident care would include pulling the privacy curtains, when providing resident care, especially when the room is a shared resident room. Registered Nurse #104 also indicated that all staff have been provided annual training regarding resident's rights. Registered Nurse #104 indicated a lack of awareness of resident #056's desire for the privacy curtains to be left open when care is being provided. Registered Nurse #104 further added that the practice is to pull privacy curtains to allow for privacy during the provision of care.

The DOC indicated that it is expected that staff pull privacy curtain when providing care. [s. 3. (1) 8.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The Licensee's policy, Nail Care-Hands (#RESI-05-07-16) directs that residents will have their fingernails cared for daily and at the bath session to ensure cleanliness of fingernails and hands. The policy directs that the procedure is documented on the daily care record.

Related to resident #048:

Resident #048 is dependent on staff for activities of daily living.

Resident #048 was observed (by the Inspector) on five consecutive days in November 2016. The resident was observed to have a dark brown substance under the fingernails during the identified dates.

The bath schedule in November 2016, indicated that the resident was to have a bath on two specified days of the week. The daily care record, had been signed by direct care staff, and indicated that resident #048 had received personal hygiene on both days and also the evenings of the identified dates. The daily care record does not identify nail care, specifically fingernail care as having been provided to resident #048.

Personal Support Workers #130 and #124 both indicated that resident #048 should have had fingernail care completed by staff. The PSWs both indicated, that nail care is to be documented when provided in the daily care record.

The licensee has failed to ensure that resident #048 received fingernail care, during a specified wee in November 2016. [s. 35. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

Related to resident #048:

Resident #048 is dependent on staff for activities of daily living, including personal hygiene, transferring and dressing.

The plan of care, specifically the written care plan currently in place, was reviewed by the inspector. The plan of care identified that resident #048 requires one staff to provide extensive assistance for activities of daily living, including dressing, personal hygiene and transferring.

Resident #048 was observed (by the Inspector) on two specified dates and time in November 2016. Resident #048 was observed sitting in the wheelchair in various locations, including, the dining room, hallway and the lounge; resident was wearing pyjamas.

Personal Support Worker (PSW) #130 indicated (to the Inspector) that on the two specified dates in November of 2016 , the resident was still in pyjamas at 1500 hours. Person Support Worker #130 indicated that residents are to be dressed in their clothes for the day, and are not to be left in their pyjamas. Personal Support Worker #130 also indicated that resident #048 does not refuse care.

PSW #130 indicated the same staff (PSW #148) was assigned to care for resident #048 during the day shifts on both of these specified dates in November 2016.

Resident #048 indicated (to the inspector) a preference to be dressed in clothes when up in the wheelchair, but at times, some staff leave the resident in pyjamas. The resident also indicated a reluctance to voice a concern as not to cause any trouble. [s. 40.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances are labelled properly and kept inaccessible to residents.

On a specified date in November 2016, a housekeeping cart was observed (by the Inspector) unattended in a hallway of the long-term care home; the housekeeping cart was observed to have cleaning agents/product on top of the cart. The cleaning agents/products were loosely stored (not locked) on the upper shelf of the housekeeping cart.

During this observation, a resident in a wheelchair was observed, by the Inspector, in the hallway.

Housekeeping Aid (HSKA) #128, who was observed leaving the housekeeping cart unattended, indicated the housekeeping cart and or cleaning agents/products are not to be left unattended. HSKA #128 indicated the housekeeping cart, used by the common area housekeeper does not lock, so it is difficult to keep the cleaning agents/products secured. HSKA #128 indicated the main hallway is a resident accessible area.

The MSDS (Material Safety Data Sheet), for the cleaning agents/products were provided to and reviewed (by the inspector); the MSDS identified the products as follows:

- Total Cleaner and Polish -WHMIS Label -Materials Causing Other Serious Toxic Effects
- Bol Genie - WHMIS Label - Corrosive Material;
- Saber Concentrated - potential hazards described are not expected when manufacturer's directions for use and proper security measures are observed; inhalation is irritating to respiratory tract; ingestion is harmful if swallowed; irritating to skin and eyes.

The Food Services Manager, who oversaw Accommodation Services, which includes Housekeeping, indicated the housekeeping cart is not to be left unattended, as the cart contains cleaning agents/products, which could be hazardous to residents. [s. 91.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is acquired, received or stored by or in the home unless the drug has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

Resident #054 has a physician order for two separate medications.

During the course of this inspection, Inspector #571 observed that these drugs were not supplied by the pharmacy but rather the resident's family. These drugs were stored in the original bottles in the bottom drawer of the medication cart. The resident's name was written in black marker on the lids of both medication but was no longer legible on one bottle.

During an interview in November 2016 with Inspector #571, the Director of Care indicated that some families provide medications in bulk because it is cheaper than having pharmacy provide the medication.

Therefore, the licensee failed to ensure that no drug is acquired, received or stored by or in the home unless it has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. [s. 122. (1)]

WN #17: 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 failed to ensure that all staff who provides direct care to residents receives training relating to abuse recognition and prevention, annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

Under LTCHA, 2007, s. 76 (7) - Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations, specific to, abuse recognition and prevention.

Related to intake #027049-16:

Activity Aid (AA) #118 was alleged to have been involved in an incident involving staff to resident abuse, which was alleged to have occurred on a specified date. AA #118 was said to be the aggressor in the alleged incident of verbal-physical abuse of resident #045.

The Administrator indicated (to the Inspector) that the home's investigation of the alleged staff to resident abuse was concluded and the allegations were founded.

The Administrator indicated, that as part of the assessed needs of the Activity Aid#118 post investigation, "AA #118 was to read the Resident's Bill of Rights, with an emphasis

on rights #02, 04, 06, 09, and #11 (ii), the Extendicare policy on Code of Conduct, and to participate in education related to residents with cognitive impairments (e.g. Montessori Methods and GPA)" As per the Administrator and as indicated by the Action Form provided to AA #118, the Code of Conduct policy, as well as the Resident's Bill of Rights was to be read and understanding acknowledged by signature no later than a specified date. The Administrator indicated to the inspector, of being unaware, if AA #118 had completed the required retraining as there was no documentation in AA#118's personnel file.

Activity Manager did not indicate (to the Inspector) an awareness that AA #118 had required any retraining, after the date of the alleged abuse incident. The Activity Manager indicated that no directions was given to provide any retraining to AA #118".

Activity Aide #118 confirmed (to the Inspector) not completing the review of the Resident's Bill of Rights or the Code of Conduct policy by the specified date in September 2016, as the information was not provided until mid-October 2016. Activity Aide #118 indicated being contacted by phone by the supervisor on a specified date in November 2016. During the conversation, the supervisor inquired if AA #118 had been instructed to complete a review of the Resident's Bill of Rights and or Code of Conduct policy. Activity Aide #118 indicated (to the Inspector), the signing a copy of the Resident's Bill of Rights and the Code of Conduct policy, on the morning that the interview with the Inspector took place (in November 2016), as requested by the supervisor and Administrator.

Activity Aid #118 believes she "read the above identified information on or about October 20, 2016". [s. 221. (2)]

Issued on this 10th day of March, 2017

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

Original report signed by the inspector.