Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 6, 2018	2018_607523_0006	005380-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare London
860 Waterloo Street LONDON ON N6A 3W6

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

ALI NASSER (523), INA REYNOLDS (524), MELANIE NORTHEY (563), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 25, 26, 27, 30, May 1, and 2, 2018.

The following Critical Incident intakes were completed within this inspection:

Critical Incident Log # 034610-16, SAC # 14201, CIS # 2173-000033-16 related to resident's hospitalization and change in condition.
Critical Incident Log # 017435-16, CIS # 2173-000019-16 related to resident's fall.

Critical Incident Log # 006363-16, CIS # 2173-000002-16 related to resident's fall.
Critical Incident Log # 028954-17, CIS # 2173-000013-17 related to medication administration.
Critical Incident Log # 000193-17, CIS # 2173-000035-16 related to resident's fall.
Critical Incident Log # 020105-16, CIS # 2173-000022-16 related to a resident's fall.
Critical Incident Log # 018317-16, CIS # 2173-000020-16 related to a resident's fall.
Critical Incident Log # 027085-17, CIS # 2173-000010-17 related to a resident's fall.
Critical Incident Log # 031570-16, CIS # 2173-000031-16 related to a resident's fall .
Critical Incident Log # 019202-16, CIS # 2173-000011-16 Fall related to a resident's fall .
Critical Incident Log # 029385-16, CIS # 2173-000028-16 related to a resident's elopement.
Critical Incident Log # 028609-17, CIS # 2173-000011-17 related to a resident's fall.
Critical Incident Log # 003593-18, CIS # 2173-000004-18 related to missing Controlled Substance.
Critical Incident Log # 004941-18, CIS # 2173-000006-18 –related to disease outbreak.

Inquiry Log # 004085-18 , related to disease outbreak.
Inquiry Log # 000963-18 related to tray service not provided to a resident.
Inquiry Log # 019356-16 related to refusal of admission.
Inquiry Log #006175-18 related to care provided to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Dietary Manager, Support Services Manager, Admission Coordinator, Clinical Pharmacist, RAI Coordinator, Wound Care Champion, Physiotherapist, eight registered staff members, 10 Personal Support Services, a nursing student attendant, Resident's Council President, Family Council President, three family members and over forty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) A Critical Incident System (CIS) Report documented that a specific resident had a fall on certain date where the resident sustained an injury and a significant change in health status.

A progress note in Point Click Care (PCC) on a certain date documented a specific equipment was provided to the resident.

The current care plan stated that a specific intervention was to be used at all times when the resident was using the specific equipment. This intervention was also part of the kardex for the resident.

On a certain date during the inspection, the resident was observed utilizing this equipment in a common area of the home, the intervention was not implemented at the time of the observation. A specific Registered Practical Nurse (RPN) verified that the specific intervention was not implemented. The RPN acknowledged that the Personal Support Workers (PSWs) who got the resident up should have implemented the intervention and did not. The RPN also verified that the care plan and kardex for the resident identified the use of the specific intervention to be in place at all times.

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.

B) The current care plan for a specific resident stated the resident used a specific intervention for falls prevention. The care plan documented a specific designation that concluded the resident specific risk for falls and was to be posted where needed and the intervention was to be placed.

On a certain date during the inspection the resident shared there should be a specific intervention in place for falls prevention. During the observation it was noted that the intervention was not implemented and the designation that specified the resident's risk for falls was wrong.

A specific Personal Support Worker (PSW) verified that the intervention was implemented for the resident at that time. The PSW said that the designation for the fall risk was wrong.

The licensee failed to ensure that the care set out in the plan of care related to fall prevention strategies was provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) A specific Critical Incident System (CIS) Report documented that a specific resident had a fall on certain date where the resident sustained an injury and significant change in health status.

The current care plan in Point Click Care (PCC) stated that the resident would participate in choosing their own clothes and make sure they are appropriate for season with extensive assistance of one to two staff. A specific Personal Support Worker (PSW) verified that this intervention was not applicable to the resident at the time.

The current care plan stated that a specific designation for fall risk was located on the resident’s specific mobility device, other interventions were identified. A specific Registered Practical Nurse (RPN) verified that the resident required total assistance and does not use the specific mobility device, and the other interventions were not applicable for the resident at that time. Specific PSWs also acknowledged that the specific interventions were not applicable at this time.

On a certain date during the inspection, the resident was observed sitting in a mobility device in their room. Interventions identified in the plan of care were not present in the room.

On a certain date during the inspection, a specific Physiotherapist (PT) stated there was a change to the level of care and participation for the resident and that the resident did not use the current specific interventions.

On a certain date during the inspection, a specific RPN acknowledged that the resident's plan of care was not reviewed and revised when the resident's care needs changed.

The current care plan stated that the resident was at a certain risk for falls and specific interventions were to be in place. Specific PSWs acknowledged that the interventions were not applicable to the resident care at this time.

The current care plan stated that the resident's Cognitive Performance Scale (CPS) would be maintained at a specific level by the next Minimum Date Set (MDS) review date. According to the Significant Change in Status MDS assessment for the specific time indicated different CPS score.

The most recent completed quarterly MDS assessment indicated a different CPS score indicating severe cognitive impairment.

The Director of Care verified that the resident's CPS score was as indicated in the MDS assessment and not as the plan of care.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or when care set out in the plan was no longer necessary.

B) The current care plan in Point Click Care (PCC) for a specific resident stated specific care interventions.

On a specific date during the inspection the resident shared specific care information that was different than the plan of care interventions.

On a specific date during the inspection the DOC reviewed the current care plan and verified that the care plan did not reflect the current level of care and staff assistance

provided to the resident.

The DOC acknowledged that the current care plan was not reviewed and revised when the resident's care needs changed.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan and that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated: abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations; and the licensee failed to ensure that appropriate action was taken in response to every such incident.

Ontario Regulation 79/10 s. (2) states, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain. O. Reg. 79/10, s. 2(1).

Ontario Regulation 79/10 s. (5) states, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

On a specific date during the inspection a specific resident was interviewed. The resident reported specific allegation of abuse and neglect by a specific PSW. The resident was interviewed again on a different date during the inspection and stated the same allegations.

On a specific date during the inspection an Inspector communicated the allegation of abuse and neglect to the Director of Care. The DOC stated that a complaint was received on behalf of the resident on a certain date about allegation of abuse from a specific PSW towards the resident and a Complaint Investigation Form was completed.

The Complaint Investigation Form was completed in response to the complaint of allegations of staff to resident abuse. The summary of the investigation documented "report made by resident about staff were founded."

A Progress note in the resident record included allegations that two specific PSWs were rude and rough toward the resident.

The Extendicare "Zero Tolerance of Resident Abuse and Neglect Program" RC-02-01-01 last updated April 2017 stated the home would promptly and thoroughly investigate all alleged or reported incidents of abuse and neglect in a fair and transparent manner.

The Extendicare "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" RC-02-01-02 last updated April 2017 stated an investigation would be

immediately initiated of the alleged, suspected or witnessed abuse.

Review of the Extendicare "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" RC-02-01-03 last updated April 2017 stated all reported incidents of abuse and/or neglect would be investigated.

On a specific date during the inspection the DOC stated the expectation when there were allegations of rough handling, staff being rude to the resident and neglect of care identified by the resident should be reported to management immediately and an investigation would be started by the DOC. The DOC verified there was no follow up by the home related to the allegation of abuse and neglect reported by the resident. A Complaint Investigation Form was not completed, the incident was not investigated, the staff were not interviewed at that time and the resident was not interviewed.

The licensee failed to ensure that every alleged incident of abuse or neglect of a resident was immediately investigated and that appropriate action was taken in response to the incident. [s. 23. (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 every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated: abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations; and the licensee failed to ensure that appropriate action was taken in response to every such incident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director, improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Ontario Regulation 79/10 s. (2) states, "For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain. "Emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident". O. Reg. 79/10, s. 2(1).

Ontario Regulation 79/10 s. (5) states, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

On a specific date during the inspection a specific resident was interviewed. The resident reported specific allegations of abuse and neglect by a specific PSW. The resident was

interviewed again on a different date during the inspection and stated the same allegations.

On a specific date during the inspection an Inspector communicated the allegation of abuse and neglect to the Director of Care. The DOC stated that a complaint was received on behalf of the resident on a certain date about allegation of abuse from a specific PSW towards the resident and a Complaint Investigation Form was completed.

The Director of Care (DOC) acknowledged that the resident reported an allegation of abuse and neglect by specific PSWs. The DOC also acknowledged that there was another reported allegation on a different date.

The Complaint Investigation Form was completed in response to a verbal complaint from the resident’s friend on a specific date. The friend reported allegations of abuse from two specific PSWs. The summary of the investigation documented "report made by resident about staff were founded.”

The Director of Care (DOC) acknowledged there were a total of three resident reported allegations of abuse or neglect. All three allegations involved specific PSWs.

The Extendicare "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" RC-02-01-02 last updated April 2017 stated an investigation would be immediately initiated of the alleged, suspected or witnessed abuse. Any employee who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager. In addition, anyone who suspects or witnesses abuse, incompetent care or treatment of a resident or neglect that may cause harm to a resident was required to contact the Ministry of Health and Long Term Care (MOHLTC) Director.

The resident continued to complain of allegations of abuse naming the specific PSWs. An alleged Abuse report was completed, and the named PSWs were removed from care. The DOC acknowledged there was evidence to support the suspicion of abuse and the incidents were not reported to the Director of the MOHLTC.

The licensee failed to ensure that improper or incompetent treatment of care of resident that resulted in harm or a risk of harm and abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm immediately reported the suspicion 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 the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director, improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Personal Assistance Services Device (PASD) used to assist a resident with a routine activity of living was included in the residents' plan of care.

A) On a specific date during the inspection a specific resident was observed using a specific mobility device.

The current care plan in Point Click care (PCC) did not have a focus, goals, or interventions related to the use of the specific mobility device by the resident.

The progress notes in Point Click Care (PCC) documented the use of the specific mobility device.

The “Least Restraint - Personal Assistance Service Device (PASD) Assessment – V2” was not completed in PCC when the use of the mobility device was first put in use.

On a certain date a specific Personal Support Worker (PSW) stated that the use of the specific device was not in the kardex and it was not in Point of Care (POC) for documentation by the PSWs. A specific Registered Nurse (RN) looked at the resident's care plan in PCC and verified that the use of the device was not documented as part of the care plan or kardex and should be.

On a certain date a specific Physiotherapist (PT) stated that a specific assessment should have been completed for the use of this device. Inspector and PT looked at the PCC documentation and the PT verified that an assessment was not done. The PT also stated that the device was in use and was not in the plan of care for the resident.

On a certain date the DOC verified that the use of the specific device was not a part of the resident's plan of care and should be and stated the specific assessment was not completed and should be. The DOC shared that POC did not include the task related to the use and monitoring of the device and should be. The DOC stated there should also be a note under the "Communications" tab in PCC by the PT identifying that the resident now required the use of this device and verified that there was no note documented.

The Extendicare Personal Assistance Service Devices (PASDs) policy #RC-22-01-05 last updated February 2017 documented that an assessment for the use of a PASD would be completed prior to the implementation of the PASD. The policy stated a PASD must reassessed at a minimum on a quarterly basis and if the resident cannot easily remove it themselves on request then the device was considered a restraint. The care plan must state the purpose and timeframe for the use of the PASD. The policy provided examples of activities of daily living (ADLs) where a PASD may be of assistance. For positioning, a physical device such as a tilt wheelchair tilted into a reclining position/tilt function may be used as a PASD to support this routine activity of daily living. The PASD device would automatically become a restraint if the resident was not able to release the physical device themselves.

The licensee failed to ensure that a PASD use to assist the resident with comfort and positioning was included in the residents' plan of care.

B) The licensee failed to ensure that the Personal Assistance Services Device (PASD)

described in subsection (1) used to assist a resident with a routine activity of living was included in the residents' plan of care.

Subsection (1) applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident was not able, either physically or cognitively, to release themselves from the PASD.

On specific date during the inspection a specific resident was observed using a specific PASD.

The current care plan in Point Click Care (PCC) did not have a focus, goals, or interventions related to the use of the specific PASD by the resident.

The progress notes in PCC documented the use of the PASD.

On a certain date a specific Physiotherapist verified that the "Least Restraint - Personal Assistance Service Device (PASD) Assessment – V2" was not completed at the time the PASD was used by the resident. The PT verified that when the PASD was used the resident's care plan should have been updated and was not. The PT verified that the resident's plan of care did not include the use of the PASD.

The licensee failed to ensure that the PASD used for the resident's care was included in the residents' plan of care. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Personal Assistance Services Device (PASD) described in subsection (1) used to assist a resident with a routine activity of living was included in the residents' plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug was administered to residents according to the directions for use specified by the prescriber.

On specific dates during the inspection an Inspector completed observations of the medication rooms, medication carts, medication administration, and drug destruction of controlled substances, documentation for medication administration on the Electronic Medication Administration Record (eMAR), and signage of controlled substances by the registered staff. Completed health care record reviews, resident care observations and any other relevant documentation at that time of the inspection.

On a specific date the MOHLTC received from the home a CIS Report related to wrong administration of a drug to a specific resident.

On a specific date the MOHLTC received from the home a CIS Report related to a missing controlled substance. There were no checks in place at the time to determine the length of time the medication was not being administrated for.

On specific date during the inspection an Inspector reviewed the homes quarterly medication incidents for a specific period of time that showed a specific resident did not receive a specific medication on a specific date. The same medication incident report for this resident also showed that the resident did not receive the correct dose of a specific medication.

The Medical Pharmacies Medication Pass Policy #3-6, February 2, 2017, stated in part that all medications administered are listed on the residents EMAR and that each resident receives the correct prescribed dosage, at the time and the correct route.

On a specific date the Director of Care (DOC) told the inspectors that the homes expectation was that drugs were to be administered to residents according to the directions for use specified by the prescriber.

The licensee has failed to ensure that the specific residents were not administered drugs according to the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 7th day of June, 2018

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

Original report signed by the inspector.