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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 4, 2019	2019_570528_0006	012261-18, 027168-18, 003610-19, 003641-19	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

BayWoods Place
330 Main Street East HAMILTON ON L8N 3T9

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Feb 19, 20, 21, 22, 2019.

This Complaint Inspection included:

Log #027168-18 and #003584-19 related to allegations of neglect
Log #012261-18 related to personal support services and food quality
Log #003641-19, log #003610-19, and CIS # 2581-00005-18, related to allegations of neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, the Wound Care Champion, the Physiotherapist, the Programs Manager, registered nurses (RN), registered practical nurses (RPN), personal support works (PSW), unit clerk, residents and families.

During the course of the inspection, the inspector observed the provision of care and services, reviewed documents including but not limited to: medical records, investigation notes, staff schedules, complaints logs, meeting minutes, policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Food Quality
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

7 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.

0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may have occurred, immediately report the suspicion and the information upon which it was based to the Director.

Complaint log # 027168-18, was submitted in October 2018, and # 003584-19, submitted in February 2019, which identified allegations of neglect of resident #002.

i. Review of the plan of care for resident #002 revealed that in September 2018, care concerns were brought to the staff's attention.
ii. Investigation notes revealed that the concerns of neglect, regarding resident #002, had been reported to DOC #118. Interview with DOC #118 in February 2019, and investigation notes confirmed that the concerns were related to neglect; however, allegations were not reported to the Director immediately.
iii. Interview with ED #100 confirmed that DOC #118, did not report allegations of neglect immediately, as required.

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 has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director, 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 home failed to ensure that every policy was complied with.

Ontario Regulation 79/10 s. 114 subsection (2), outlines that the licensee was to ensure that written policies and procedures were developed for the medication management system to ensure accurate administration of all drugs used in the home.

A. The home's policy "Medication-Medication Administration", last revised in March 2018, directed registered staff that all medication administered, refused or omitted will be documented immediately after administration on the electronic medication administration record (eMAR) using the proper codes by the administering nurse.

During the course of the inspection, the registered staff failed to document the administration of medications on the eMAR, as follows:

i. Complaint log #003641-19, was submitted in February 2019, which identified concerns related to neglect of resident #001.

Review of the medical records for resident #001, identified that the resident had multiple diagnosis and was at risk for bowel pattern changes. Physician orders included a bowel protocol. A progress note in February 2019, identified that the resident had medications according to the bowel protocol by RN #103. Review of the eMAR, did not include documentation of the administration of the medication. Interview with ADOC #102, in February 2019, confirmed that on the identified day in February 2019, RN #103 did not document the medication administration on the eMAR, as required.

ii. Review of medical records for resident #002 identified they were at risk for bowel changes related to multiple diagnosis. Physician orders included a bowel protocol. Review of the progress notes revealed that on an identified day in February 2019, the resident had medication administered. Review of the eMARs did not include documentation of the medication administration. Interview with ADOC #102 confirmed that in February 2019, medication administration was not documented on the eMARS, as required. [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 every plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A. Complaint log #003641-19, was submitted in February 2019, identified concerns related to neglect of resident #001.

i. Review of the medical records for resident #001, identified that they had multiple diagnosis and required specific medication.
ii. A progress note on a specified day in February 2019, identified that the specific medication was administered to the resident by RN #103. Review of the Point of Care (POC) documentation from February 2019, revealed that staff had documented that the resident di not required the medication.
iii. Interview with RN #103, in February 2019, confirmed they administered the medication to the resident. In addition, the RN #103 also confirmed that they did not check POC documentation or check with PSW staff to ensure that the resident did not require the medication. Interview with ADOC #102, in February 2019, confirmed that on an identified day in February 2019, RN #103 proceeded to administer the specified medication to resident #001; however this was not according to the directions for use as ordered by the prescriber.

B. Review of medical records for resident #002 identified they were at risk and required specific medications. Review of the progress notes revealed that on an identified day in February 2019, the specified medications were given to the resident. Review of POC documentation indicated that the resident had not required the medication.
ii. Interview with ADOC #102 confirmed that on a specified day in February 2019, medications were not given in accordance with the directions for use for resident #002.
[s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The home's policy "Personal Care:CARE14-O10.02", last revised March 2018, identified that resident nail care was included in the residents hygiene experience according to the resident's individual needs and that all specified residents received foot care from a qualified foot care provider or the nurse. In addition, any changes or abnormalities were to be documented.

A. Complaint log #027168-18, submitted in October 2018, identified care concerns for resident #002.

i. Review of the plan of care for resident #002 identified they had multiple diagnosis and required assistance with activities of daily living. Registered staff were required to provide nail care weekly. From June to September 2018, the electronic treatment administration records (eTARS) showed that registered staff documented that weekly nail care was completed.
ii. In September 2018, registered staff #107 documented that nail care was provided. A few days later, concerns were brought forward to the home. In October 2018, after the concerns were brought forward, a progress note documented that the nails required care.

iii. Interview with registered staff #107 in February 2019, confirmed that on the identified day in September 2018, they had provided nail care only. Registered staff #107 also indicated that the nails were assessed and the assessment should have been documented in a progress note.
iv. Review of the progress notes from June to September 2018, did not include any

documentation related to the resident's nails. Interview with ADOC #102 in February 2019, confirmed that it was the responsibility of registered staff to complete nail care, to document any irregularities and inform the physician as necessary. Registered staff failed to provide specified care weekly, resulting in the resident #002's nails requiring treatment.
v. Interview with ADOC #102 in February 2019, revealed that after June 2018, the specified provider in the home was in the process of finding a new nail care provider.

B. Review of the plan of care for resident #006 identified that the resident had multiple diagnosis and required the assessment and completion of nail care by registered staff weekly.
i. From June to December 2018, registered staff documented that nail care was completed weekly. Review of the progress notes in May 2018, revealed that the resident was treated by external services, no concerns were noted at that time. In October 2018, registered staff documented that nail care was completed and there were no concerns.
ii. In December 2018, a progress note documented that the resident's nails required specialized treatment. Several days later, the resident was seen by an external care provider and it was documented that the nails required care.
iii. Interview with RN #105 confirmed that registered staff were to complete weekly nail care for the resident. Interview with ADOC #102 confirmed that weekly nail care was not provided to the resident resulting in the residents nails requiring care in December 2018.

iv. Interview with the ADOC #102 in February 2019, confirmed that the home retained a specified care provider in December 2018. [s. 35. (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 each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Review of CIS #2581-000005-19, intake log # 003610-19 and 003641-19, submitted in February 2019, identified allegations of neglect related to skin care for resident #001.

i. Review of resident #001's records, identified that the resident was admitted to the home in 2018, with altered skin integrity requiring care and treatments.
ii. Review of assessments from January 2019, revealed an improvement in the condition of the altered skin integrity, when compared to admission assessments.
iii. Review of the plan of care identified that the resident was transferred to hospital,

returning to the home in February 2019. Review of assessments and progress notes on the resident's return from hospital, which did not include any assessment of the condition of the altered skin integrity. Two days later, assessments were completed using a clinically appropriate assessment tool. Review of photographs and interview with the Wound Care Champion confirmed that the residents altered skin integrity had changed while in hospital; however, as assessment was not completed on readmission back to the home. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of CIS #2581-000005-19, log # 003610-19 and 003641-19, submitted in February 2019, identified allegations of neglect related to skin and wound care for resident #001.

i. Review of the medical records for resident #001 identified that they were admitted to the home in 2018. Assessments included documentation of altered skin integrity requiring ongoing treatment.
ii. Interview with the Wound Care Coordinator in February 2019, revealed that upon admission the resident had altered skin integrity requiring ongoing treatment which had improved while in the home.
iii. The home's policy "Skin and Wound Care:Bruises, Rashes, IAD and Abrasions", revised March 2018, directed staff to assess the altered skin integrity and document in Interdisciplinary Progress Notes every seven days minimum or more frequently as indicated.
iv. Review of the plan of care did not include weekly assessment notes of the altered skin integrity consistently in December 2018 and January 2019.
v. Interview with the Wound Care Coordinator confirmed that assessment was not completed every seven days, as required in the home's policy. [s. 50. (2) (b) (iv)]

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:
i. that the resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return from hospital,
ii. that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Complaint log #012261-18, was submitted June 7, 2018, identified specified concerns.

I. Review of the plan of care for resident #003 identified that they were admitted to the home in 2014. Review of medical chart and Point Click Care (PCC) identified that the resident made their own decisions for care and that they had a next of kin.
ii. Review of the progress notes identified that in 2018, the resident was transferred to the hospital for assessment and treatment; however, there was no documentation to support that the next of kin was notified of the hospital transfer. Documentation in the progress notes stated the hospital had contacted the next of kin.
iii. Interview with ED #100 confirmed that although the resident was able to make their own decision, the next of kin had been actively involved in the development of the plan of care. Interview with the ED in February 2019, confirmed that staff failed to notified the next of kin of resident #003's transfer to hospital in 2018, and it would be the expectation that staff would have notified them.
iv. The designate of resident #003 was not provided the opportunity to participate fully in the development and implementation of the plan of care, related to their hospital transfer. [s. 6. (5)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10

business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. Every licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
1. The complaint should have been investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more

residents, the investigation should have been commenced immediately.
2. For those complaints that could not be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint should have been provided within 10 business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response that complies with paragraph 3 should have been provided as soon as possible in the circumstances.
3. A response should have been made to the person who made the complaint, indicating, i. what the licensee had done to resolve the complaint, or ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

Review of Complaint Log #012261-18, submitted in June 2018, revealed concerns related to notification of hospitalization of resident #003.

i. The home's policy "Complaint Management Policy: ADMIN3-O10.01", revised June 2018, outlined that if concerns could not be resolved immediately at point of service, the individual who was first aware of a concern would initiate the Client Service Response (CSR) Form. A copy of the initial form would be forwarded to the Executive Director and to the member of the team who would be responsible for the resolution of the concern. The concern would be responded to within 24 to 48 hours (2 business days). The person who raised the concerns would be informed of the actions being taken to resolve the concern. Investigation of issues would be concluded within 10 business days. If the complaint could not be resolved within 10 business days the complainant should have been notified of the actions taken to date and provided with a date upon which he/she could expect a resolution. The CSR form was then to be completed in full and filed in Complaints Management Binder.
ii. Review of the plan of care for resident #003 revealed that they had family listed as 'next of kin'. Review of medical records and consent documentation identified that the resident made their own care decisions; however, their next of kin was also included in the development of the plan.
iii. Review of the progress notes revealed that in 2018, the resident was transferred to hospital for assessment and treatment. Several days later, concerns were expressed to registered staff related to the transfer. Review of the 2018 Complaint Management Binder did not include a Client Service Response (CSR) Form, related to the issue.
iv. Interview with ED #100 in February 2019, confirmed that a CSR was not completed for the documented concern related to resident #003; the management were not aware of the issue and therefore no follow up was completed, as required. [s. 101. (1)]

2. The licensee failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

Review of Complaint Log #027168-18, submitted in October 2017, identified allegations of neglect of resident #002.

i. Review of the plan of care for resident #002 identified that in September 2018, family of the resident expressed care concerns about the resident. Interview with DOC #118 in February 2019, confirmed that they were aware of the concerns and actions were taken to resolve the concerns, including assessment and treatment.
ii. Review of the 2018 Complaints Management Binder, did not include the documented concerns related to resident #002, the actions taken to resolve the concern and final resolution.
iii. Interview with ED #100 in February 2019, and review of CIS confirmed that the home had assessed and treated the resident; however, the information was not documented in the Complaints Management Binder. [s. 101. (2)]

3. The licensee failed to ensure that the documented record (of complaints received) was reviewed and analyzed for trends, at least quarterly, the results of the review and analysis were taken into account in determining what improvements were required in the home, and a written record was kept of each review and of the improvements made in response.

Review of Complaint log # 027168-18, submitted in October 2018, identified concerns related to the homes process for dealing with complaints.

During the course of the inspection the 2017 and 2018 Complaint Management Binder was reviewed and revealed that the home documented the Client Service Response (CSR) forms in a binder and then tracked the information on a tracking sheet. Interview with ED #100 confirmed that for the year 2017, an annual review and audit of the

complaints was done in December 2017. The documented complaints from 2017 were not reviewed at least quarterly, as required. In addition, no complaint audits were provided for 2018. Interview with ED #100 confirmed that they were new in the role and the ED from 2017 and 2018 was not available for an interview. [s. 101. (3)]

Issued on this 11th day of March, 2019

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

Original report signed by the inspector.