Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Dec 31, 2015	2015_393606_0012	T-1776-15	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

YORK REGION NEWMARKET HEALTH CENTRE
194 EAGLE STREET NEWMARKET ON L3Y 1J6

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

JANET GROUX (606), NITAL SHETH (500), THERESA BERDOE-YOUNG (596)

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): August 18, 19, 20, 21, 24, 25, 26, 28, 31, and September 1, 2015.

During the course of this inspection, four critical incidents (CI) and two follow up (FU) inspections were completed.

During the course of the inspection, the inspector(s) spoke with the Administrator (A), Director of Care(DOC), Supervisor, Programs and Services(PSS), Supervisor of Care(SOC), Food Service Supervisor(FSS), Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Dietary Aide, Food Service Worker, Activationist, Housekeeping, Physiotherapist, Maintenance, Building Service Engineer, Supervisor of Maintenance and Security, the President of the Residents' Council, a representative of the Family Council, Residents, and Substitute Decision Makers(SDM).

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

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

12 WN(s)
1 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. 3. (1)	CO #001	2014_163109_0023	606
LTCHA, 2007 S.O. 2007, c.8 s. 65.	CO #002	2014_163109_0023	606

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

Findings/Faits saillants :

1. The licensee has failed to ensure that that there is a written plan of care for each resident that sets out to staff and others who provide direct care to the resident.

During the initial tour, the inspector observed a sign on an identified resident's door indicating routine precautions.

Review of the resident's plan of care revealed that the plan of care did not address the resident's condition and interventions.

Interview with an identified PSW revealed that he/she was not aware of the resident's plan of care regarding the condition and confirmed that it was not included in the plan of care.

Interview with an identified RPN revealed that the resident was admitted with an identified condition and confirmed that the condition and related interventions were not included in the written plan of care.

Interview with the DOC confirmed that the resident written plan of care did not set clear directions related to his/her condition. [s. 6. (1) (c)]

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

Record review of a CI report and the home's investigation records revealed that an

identified resident sustained a fall on an identified date while two identified PSWs were assisting the resident to walk from bed to toilet.

Review of the resident's clinical records revealed that the resident had a previous fall on an identified date. Post fall, the resident's plan of care was updated and indicated no walking until further notice, and physiotherapy mobility assessment completed on an identified date, directed staff to perform two person assist pivot transfers, on the right leg from bed to wheelchair and wheelchair to bed.

Interviews with the physiotherapist, DOC, and an identified PSW revealed the two identified PSWs assisted the resident to walk to the bathroom on an identified date when resident suddenly slipped to the floor. The resident's plan of care indicated no walking until further notice.

The DOC and the identified PSW confirmed that they should have performed a two person assist pivot transfer as indicated in the resident's plan of care, and did not. The PSW confirmed that he/she did not read the resident's kardex and care plan before providing care to the resident on the identified date, and assisted the resident to walk from bed to toilet. [s. 6. (7)]

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 written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents is fully respected and promoted: every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date and time, on an identified unit, the inspector observed a point of care (POC) monitor left unattended, displaying a resident's personal health information and visible to anyone walking by.

Interview with an identified PSW revealed that staff are to log off from the POC monitor after using it and confirmed that a staff member had forgotten to log off. The identified PSW then logged off the POC.

Interview with the DOC confirmed that staff must log off from the POC after use to ensure residents' health information is kept confidential. [s. 3. (1) 11. iv.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of an identified CI report revealed that on an identified date and time, an identified resident eloped from the home at an identified time while wearing an audible device on his/her arm and was found ten minutes later outside the home. Record review of the home's policy directs staff to locate and then relocate the resident away from the door or restricted area when the alarm sounds.

Interviews with three of the home's management staff revealed an identified RPN cancelled the device without first locating and relocating the resident away from the door as the home's policy directs them to do.

The identified RPN was not available to be interviewed, but the DOC confirmed that the staff was disciplined for his/her actions.

WN #4: 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Review of an identified critical incident report (CI) on an identified date, indicated an identified resident's substitute decision maker(SDM) expressed concerns that he/she suspected abuse due to increased impaired skin integrity on an identified area of the resident.

Review of the home's investigation records indicated that resident had a history of impaired skin integrity due to a medication he/she was taking.

Review of the home's investigation records included only an interview with the SDM on an identified date, to verify his/her concern and to review the interventions that the home would put in place to prevent further impaired skin integrity of the resident. The investigation records did not include interviews with staff and others and was incomplete.

Interview with the SDM revealed that he/she was concerned about the impaired skin integrity on the identified area of the resident and stated "it looked like someone grabbed the resident abruptly and was rough."

Interview with the DOC confirmed the home concluded without further investigation that resident's impaired skin integrity was caused by the medication and that the allegation and suspected abuse was unfounded. [s. 23. (1) (a)]

2. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Record review of an identified CI report and interview with DOC revealed that a CI reporting an allegation of abuse was submitted to the Director on an identified date, amended on an identified date, and that one of the home's SOCs was responsible for updating and closing off the CI, and it was not done.

DOC confirmed that the above mentioned CI was not updated with results of the investigation for the allegation of staff abuse of resident #022. [s. 23. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: the program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the home's Continence Care and Bowel Management Program revealed that there was no Continence Care and Bowel Management Program evaluation records available.

A review of the home's Continence Care and Bowel Management Program, with an identified date, indicated "this program will be evaluated and updated annually in accordance with evidence-based practices."

Interview with DOC confirmed that the home did not conduct an annual evaluation of Continence Care and Bowel Management in 2014. [s. 30. (1) 3.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program is, at a minimum, provide for the following: annual evaluation of residents' satisfaction with the range of continence care products in consultation with direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

A review of the home's annual Resident Survey indicated that the home did not complete an annual evaluation of residents' satisfaction with the range of continence care products in consultation with direct care staff.

A review of the home's Continence Care and Bowel Management Program, on an identified date, indicated, "there will be an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision makers and direct care staff, with the evaluation being taken into account by the home when making purchasing decisions, including when vendor contracts are negotiated or renegotiated".

Interview with DOC confirmed that the home completed an annual evaluation of

residents' satisfaction with the range of continence care products involving residents and families however, direct care staff were not involved in the evaluation. [s. 51. (1) 5.]

2. The licensee has failed to ensure that, each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Interview with an identified PSW revealed that the identified resident was incontinent for bladder and continent for bowel and was using an incontinent product.

A review of the resident's plan of care revealed that the resident had urinal incontinence related to his/her medical diagnoses.

A review of the resident's assessment records indicated that an incontinence assessment was not completed for the resident.

Interview with an identified RN confirmed that he/she could not find the incontinence assessment for the resident.

Interview with DOC confirmed that the continence care and bowel management program was recently revised in an identified date in 2015, and prior to that, residents' were not assessed by using a clinically appropriate tool which includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations:
-The Residents' Bill of Rights,
-The home's policy to promote zero tolerance of abuse and neglect of residents,
-The duty to make mandatory reports under section 24,
-The whistle-blowing protections.

Review of the home's 2014 training records revealed that not all staff receive the above training in 2014.

An interview with DOC confirmed that not all staff received the above training requirements. [s. 76. (4)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Record review of the home's family satisfaction survey for 2014, and interview with the Administrator revealed that there were no questions included in the survey measuring the residents' satisfaction of the programs provided in the home such as falls prevention, and skin and wound. [s. 85. (1)]

2. The licensee has failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Record review of the home's resident satisfaction survey for 2014, and interview with the Administrator revealed that there were no questions included in the survey pertaining to programs provided in the home such as falls prevention and skin and wound. [s. 85. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Review of an identified CI report on an identified date, indicated an identified resident's SDM expressed concerns to the home that he/she suspected abuse due to increased impaired skin integrity on an identified area of the resident's body.

Interview with the SDM revealed he/she was concerned about the impaired skin integrity on the identified area of the resident's body because "it looked like someone grabbed the resident abruptly and was rough."

Interview with the DOC revealed that although the home verified during an interview with the SDM that abuse was alleged or suspected, the police were not notified. [s. 98.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, that the results of the analysis undertaken under clause (a) are considered in the evaluation; that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Review of the home's abuse policy evaluation in 2014, did not indicate information such as the names of the persons who participated in the evaluation, and the dates the changes and improvements were implemented.

Interview with DOC revealed that the home's abuse policy evaluation for 2014 did not include the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented. [s. 99.]

WN #11: 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. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training is provided to all staff who provide direct care to residents: falls prevention and management.

A review of the home's training records and an interview with an identified SOC revealed that not all of the direct care staff receive training in Falls Prevention and Management in 2014. [s. 221. (1) 1.]

2. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training is provided to all staff who provide direct care to residents: continence care and bowel management.

A review of the home's training record and interview with the DOC confirmed that the home did not complete training in Continence Care and Bowel Management in 2014. [s. 221. (1) 3.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program.

On an identified date and time, on an identified resident home area, the inspector observed that an identified dietary aide did not performed hand hygiene after cleaning

the servery counter prior to serving the main course to the residents.

Interview with the identified dietary aide confirmed that he/she should have performed hand hygiene after cleaning the servery counter and prior to serving the main course to the residents.

A review of the home's policy indicated that "Staff and volunteers must complete hand hygiene according to the home's hand hygiene program on entering the dining area, frequently throughout the meal service and between services to each resident”.

Interview with the Food Service Supervisor (FSS) confirmed that the identified dietary aide should have performed hand hygiene after cleaning the servery counter and prior to serving the main course to the residents. [s. 229. (4)]

2. On an identified date and time, the inspector observed in an identified room, three unlabelled washbasins, and four toothbrushes, and in another identified room, a used yellow coloured bar of soap on the sink, a blue urinal and white urinal with traces of urine in it.

Interviews with an identified PSW and RPN revealed that the above mentioned items should be labelled and were not.

An interview with DOC confirmed that the home's expectation is for all resident personal care items are labelled at all times. [s. 229. (4)]

3. The licensee has failed to ensure that residents are offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A Review of five identified residents' immunization records revealed these residents were not offered immunization for tetanus and diphtheria.

Interview with an identified RPN and the DOC confirmed that the home should have offered tetanus and diphtheria immunization to the above residents and were not. [s. 229. (10) 3.]

Issued on this 29th day of January, 2016

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

Original report signed by the inspector.