Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

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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
Jan 29, 2015	2014_265526_0029	T-000072-14	Resident Quality Inspection

Licensee/Titulaire de permis

The Credit Valley Hospital and Trillium Health Centre
150 Sherway Drive ETOBICOKE ON M9C 1A5

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

McCall Centre Long Term Care Interim Unit
140 Sherway Drive ETOBICOKE ON M9C 1A4

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

THERESA MCMILLAN (526), JESSICA PALADINO (586), LESLEY EDWARDS (506), VALERIE GOLDRUP (539)

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): December 15, 16, 17, 18, and 19, 2014.

Critical Incident Inspection 340-14 was inspected simultaneously to this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Executive Director, Director of Care (DOC), Manager Environmental Services, Dietary Manager, Physiotherapist, Registered Nurse (RN), Charge Nurse, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Long Term Care (LTC) Inspectors also reviewed resident health records, training and education records, policies and procedures, dietary menus, and program evaluations. The LTC Inspectors toured the home, observed meal service, residents and staff.

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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

18 WN(s)
9 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

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 resident's right to be treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity was fully respected and promoted.

Resident #006's health record indicated that they had disturbances in mobility and in mood. Progress notes indicated that the resident used the call bell frequently to ask for assistance and express concerns and anxieties.

During interview on December 15 and 17, 2014, resident #006 told the LTC Inspector that approximately one month ago, staff had threatened to take the call bell away because they had been using it so frequently. The resident stated that staff had taken their call bell away in that they placed it beside the resident but so that the resident could not reach it due to their health limitations. The resident stated that they had to yell for staff because they couldn't find or reach the bell. According to the resident, staff then threatened to close the resident's bedroom door on night shift because the resident was calling for assistance frequently. The resident stated that staff's threatening to remove the call bell and to close the door made them feel "very, very bad" and "afraid"; "what if something happen to me and nobody would know?".

The document the home referred to as the "care plan" completed in November, 2014, did not include direction to staff that the resident's call bell should be within reach on the side of the resident so that they could see and reach it. Front line staff interviewed by the LTC Insepctor stated that they were not aware of incidents where the resident's call bell was not accessible to them.

On December 16, 2014, the LTC Inspector informed the Charge Nurse who stated that they knew about these complaints and felt the complaints were unfounded. The LTC Inspector informed the DOC on December 16, 2014, of resident #006's statements and Charge Nurse's response. The LTC Inspector also informed the Administrator on December 17, 2014.

During interview with the LTC Inspector, the DOC stated that they interviewed resident #006 who told the DOC that the call bell had been placed in a way that the resident could not reach it. The DOC confirmed that staff had threatened to close the resident's door. The DOC confirmed that the actions could be considered "borderline abuse" and that the actions of the staff were disrespectful to the resident. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

A) Resident #100 was diagnosed with an infection during the last quarter of 2014. The RN and DOC confirmed that the resident was then placed on restrictive isolation and not allowed to leave their room. The home's policy did not direct staff to isolate the resident to their room but to initiate contact precautions. The personal support worker (PSW) confirmed that, with some direction and assistance, the resident could follow instructions, was not bedridden, and was able to comply with general hygiene practices. However, during this time, the resident was required to eat in their room, could not leave their room for a shower, socialize or go outside. The restriction of resident #100's movements did not fully respect the resident's needs. (506)

B) During an interview with a family member of resident #001, the family member described two events that occurred during a two day time frame approximately two months ago.

During interview with the LTC Inspector, the family member described how they found the resident one morning sitting in their chair with no clothes on and a PSW was not in the room to provide care. The family member then described finding the resident the next day sitting on the toilet unattended and that the PSW did not return to the room to assist the resident until summoned.

The written plan of care described that the resident required one PSW total assist for dressing and staff to provide support and encouragement for toileting. The family member was not satisfied with the care received and put forth a verbal complaint to the home. A member of the registered staff and the Director of Care (DOC) confirmed that the events had been brought to their attention and the PSW had been removed from providing care on the unit. (539)

C) The document that staff used to direct care and that the home referred to as resident #006's "care plan", indicated that staff were to use a specific shower chair when bathing resident #006. During interview with LTC Inspector, the resident stated that they had pain when a different chair was used. The resident complained that staff used another, less comfortable chair during their two most recent bath days. The resident stated that they told staff that the different chair was uncomfortable and asked to use the chair as per their usual routine. The resident stated that staff told them it wasn't available, that the chair they could use would be fine, and that the shower wouldn't take too long. The resident stated that they were crying by the end of the shower due to pain and discomfort.

The DOC investigated the resident's complaint and confirmed that resident #006's care was not provided in a manner consistent with the resident's needs. [s. 3. (1) 4.]

3. The licensee has failed to ensure that residents' rights to have his or her personal health information kept confidential in accordance with the Act, was respected and promoted.

Between December 15 and 19, 2014, LTC Inspector observed both used and disposed medication packages containing residents' personal health information located in the garbage attached to the side of the medication cart. The cart was located in the hallway and accessible to residents and visitors who walked by. A RPN was observed dispensing medications and placed used packages into the garbage. They stated that this was their usual practice. The Charge Nurse confirmed that the used medication packages contained personal health information. The Charge nurse also confirmed that when the packages were disposed of in the garbage, they would be accessible to others, and the personal health information not kept confidential. [s. 3. (1) 11. 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 that residents' rights 1. to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, and 4. to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, was fully respected a promoted, to be implemented voluntarily.

WN #2: 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).

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 has failed to ensure that there was a written plan of care for each resident that set out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident.

The Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment identified resident #002 had infections within the last 30 days. The assessment also noted that there was monitoring of an "acute medical condition". A review of the written plan of care for that time period did not identify the treatment required to manage the above conditions. The LTC Inspector confirmed with a member of the registered staff, that for treatment of acute conditions, an information alert was added in the computer system to inform the registered staff. However, it was only added to the daily multiple resident log sheet; the individualized plan of care that was accessible to the PSWs was not updated. Therefore, the written plan of care for each individual resident did not provide the PSW staff with clear direction regarding resident #002's care. [s. 6. (1)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided

to the resident as specified in the plan.

A) On December 15, 2014 at approximately 1430 hours and on December 17, 2014, at approximately 1100 hours, resident #001 was observed to have a musculoskeletal condition with no treatment device in place. A sign above the bed directed staff to apply the device in the morning after morning care and to remove the splint after bedtime care. The Physiotherapist and registered staff confirmed that the unit staff were to apply the device. The home did not ensure that resident #001 had their treatment device applied as specified in the plan. (539)

B) On December 15, 2014 at approximately 1530 hours and on December 17, 2014, at approximately 1100 hours, resident #300 was observed to have a musculoskeletal condition with no treatment device in place. A sign above the bed directed staff to apply the device during morning care and remove it at bedtime care. The Physiotherapist and registered staff confirmed the unit staff were to apply the device. The home did not ensure that resident #300 had their treatment device applied as specified in the plan. (539)

C) The document that staff used to direct care and that the home referred to as resident #006's "care plan" completed in 2014, indicated that staff were to use a specific shower chair when bathing resident #006. During interview with LTC Inspector, the resident stated that they had pain when a different chair was used. The resident complained that staff used another, less comfortable chair during their two most recent bath days. The resident stated that they told staff that the different chair was uncomfortable and asked to use the chair as per their usual routine. The resident stated that staff told them it wasn't available, that the chair they could use would be fine, and that the shower wouldn't take too long. The resident stated that they were crying by the end of the shower due to pain and discomfort. The DOC investigated the resident's complaint and confirmed that resident #006's care was not provided as stated in the resident's plan of care. (526)

D) Resident #006 was prescribed a treatment to be administered three times per day for altered skin integrity. Review of the resident's electronic treatment administration record (eTAR) for one month in 2014, indicated that the resident had not received the medication three times per day on five days. Progress notes indicated that the resident had not refused the medications. The Charge Nurse confirmed that if the eTAR indicated that the treatment had not been dispensed, and if progress notes did not indicate that the resident had refused the treatment, that the treatment had not been provided according to the plan of care. [s. 6. (7)] (526)

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when a goal in the plan is met.

The RAI MDS assessment completed in 2014 identified resident #002 as being resistant to care. The written goal on the plan of care stated that the resident would have less episodes of resistance to care after a period of six months. The RAI MDS assessment completed six months later no longer noted that the resident was resistant to care. The written plan of care completed six months after the first RAI MDS assessment had not been updated to reflect that the behaviours had been reassessed and had improved. A member of the registered nursing staff confirmed this. [s. 6. (10) (a)] (539)

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 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse or neglect of residents was complied with.

The home's policy for "Resident Abuse – Staff to Resident" number OPER-02-02-04, last reviewed November, 2013, directed staff to "immediately report (verbally) any suspected

or witnessed abuse to the Administrator, Director of Care, or their designate....must report the incident, as required by the provincial legislation and jurisdictional requirement...to the MOHLTC Director through the Critical Incident Reporting System/afterhours pager…"; and, "anyone who suspects or witnesses abuse and/or neglect that causes or may cause harm to a resident is required by the LTCHA 2007 to contact the Ministry of Health and Long Term Care (Director) Action Line at..."

Resident #006 had conditions that caused disturbances in mobility and in mood. Progress notes indicated that the resident used the call bell frequently to ask for assistance. During interview on December 15, 2014, resident #006 told the LTC Inspector that approximately one month ago staff had threatened to take the call bell away because they had been using it so frequently. The resident stated that staff had taken their call bell away in that they placed it beside the resident but so that the resident could not reach it due to their health limitations. The resident stated that they had to yell for staff because they couldn't find or reach the bell. According to the resident, staff then threatened to close the resident's bedroom door on night shift because the resident was calling for assistance frequently. The resident stated that staff's threatening to remove the call bell and to close the door made them feel "very, very bad" and "afraid"; "what if something happen to me and nobody would know?".

The resident complained to the Charge Nurse but the resident told the LTC Inspector that they felt that the issue had not been resolved. On December 16, 2014, the LTC Inspector informed the Charge Nurse of resident #006's concerns. The Charge Nurse stated that they knew about these complaints and felt they were unfounded. The Charge nurse confirmed that the document the home referred to as the "care plan" indicated that the resident had "multiple unfounded complaints of staff" and the removal of the resident's call bell was one of these unfounded complaints.

On December 16, 2014, the LTC Inspector informed the DOC of resident #006's statements and about the Charge Nurse's belief that the concerns were unfounded. On December 17, 2014 the Administrator was notified by the LTC Inspector about the resident's complaint and discussions with the Charge Nurse and DOC.

On December 17, 2014, during interview with the LTC Inspector, the DOC stated that they interviewed the resident who told the DOC that the call bell had been placed in a way that the resident could not reach it. The DOC confirmed that staff had threatened to close the resident's door. The DOC confirmed that the actions could be considered "borderline abuse" and that the actions of the staff were disrespectful to the resident. The

DOC stated that they would continue to investigate the resident's concerns.

During interview with the LTC Inspector on December 18, 2014, the DOC and the Administrator stated that the home had not reported the suspected abuse that may have caused harm to the resident, to the MOHLTC using the Critical Incident System. The DOC and Administrator confirmed that the home's "Resident Abuse – Staff to Resident" had not been complied with. [s. 20. (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, without in any way restricting the generality of the duty provided for in section 19, that there is in place, a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a care conference of the interdisciplinary team who provided the resident's care was held annually that the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct were given an opportunity to participate fully in the conferences.

On December 15, 2014 during interview with the family members of residents #001 and #004, the family members could not recall being invited to an annual care conference in regards to their family members' care. The Director of Care (DOC) confirmed that the Social Worker was responsible for inviting the family members. Review of the Social Workers records and the two residents' records by the DOC confirmed the conferences had occurred but the attendance of the family members could not be confirmed. [s. 27. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; and (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences, to be implemented voluntarily.

WN #5: 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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a personal assistance services device (PASD) was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.

A) Resident #001 was observed in bed with two assist rails in the raised position on December 15, 2014. The resident's plan of care indicated that the resident used two assist rails in the up position for mobility and positioning while in bed. Review of the resident's health record indicated that resident #001 had not been assessed for the use of a bed rail as a PASD. During interview with the LTC Inspector, the Charge Nurse and DOC confirmed that the resident used the bed rails as a PASD. They also confirmed that the use of the rails as a PASD had not been assessed in terms of resident #001's physical and mental condition and personal history and whether the PASD was the least restrictive and effective device to assist the resident with the routine activity of living. (539)

B) Resident #008 was observed in bed with two quarter rails in the raised position on December 15, 2014. The resident's plan of care indicated that the resident used two assist rails in the up position for mobility while in bed. Review of the resident's health record indicated that resident #008 had not been assessed for the use of a bed rail as a PASD. During interview with the LTC Inspector, the Charge Nurse and DOC confirmed that the resident used the bed rails as a PASD. They also confirmed that the use of the rails as a PASD had not been assessed in terms of resident #008's physical and mental condition and personal history and whether the PASD was the least restrictive and effective device to assist the resident with the routine activity of living. (539)

C) Resident #006 was observed in bed with two half rails in the raised position on December 17, 2014. The resident's plan of care indicated that the resident used an assist rail in the up position for mobility and positioning while in bed. Review of the resident's health record indicated that resident #006 had not been assessed for the use of a bed rail as a PASD. During interview with the LTC Inspector, the Charge Nurse and DOC confirmed that the resident used the bed rails as a PASD. They also confirmed that the use of the rails as a PASD had not been assessed in terms of resident #006's physical and mental condition and personal history and whether the PASD was the least restrictive and effective device to assist the resident with the routine activity of living. [s. 33. (4) 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 the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) Resident #009 was assessed as a high risk for falls using the Morse Falls Risk Assessment completed during a month in 2014. According to the resident's health record, resident #009 fell approximately one month later and the resident was diagnosed with a fracture. Review of the resident's health record indicated that the post falls assessment had not been completed after the fall for resident #009 using a clinically appropriate assessment instrument that was specifically designed for falls. The RN confirmed this and stated that the post falls assessments for resident #009 should have been completed. (506)

B) Resident #010 was assessed as a high risk for falls using the Morse Falls Risk Assessment completed during a month in 2014. According to the resident's health record, resident #010 fell approximately one month later. Review of the resident's health record indicated that the post falls assessment had not been completed after the fall for resident #010 using a clinically appropriate assessment instrument that was specifically designed for falls. The RN confirmed this and stated that the post falls assessment should have been completed for resident #010. (506)

C) Resident #003 was assessed as a high risk for falls using the Morse Falls Risk Assessment completed during a month in 2014 and four months later. Interview with registered practical nurse (RPN) confirmed this. According to the resident's health record, resident #003 fell five times during a one month period that fell between these two assessments. Review of the resident's health record indicated that post falls assessments had not been completed after these five falls for resident #003 using a clinically appropriate assessment instrument that was specifically designed for falls. The RN confirmed this and stated that the post falls assessments should have been completed for resident #003. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: 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,
(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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #010 was admitted to the home on a day in 2014 with altered skin integrity. Wound assessments were not completed weekly after admission:
i) the month after admission, zero of an expected three assessments were completed;
ii) the second month after admission, zero of an expected four assessments were completed.

The RN confirmed that the weekly wound assessments were not completed weekly for resident #010 after their admission to the home. [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 that (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is (iv) reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: 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. (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).

s. 51. (2) Every licensee of a long-term care home shall ensure that, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) Resident #006's RAI MDS assessment completed on a day in 2014, indicated that resident was incontinent of urine. PSW staff confirmed this. The resident was diagnosed with a urinary condition six weeks later and received treatment. Review of the resident's health record indicated that a continence assessment had not been completed that assessed the causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. During interview with the LTC Inspector, the Charge Nurse confirmed that a continence assessment had not been conducted for resident #006. (526)

B)Resident #008's most recent documented plan of care directed staff to implement a toileting programme for the resident. Review of resident #008's most recent RAI MDS assessment, revealed that during the observation period, the resident was not on a toileting programme. Interview with registered and non-registered staff on December 19,

2014 confirmed that the resident was not on a toileting programme and only used pads or briefs. Review of the resident's health record indicated that a continence assessment had not been completed that assessed the causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. The resident's continence care needs were not reassessed when their needs changed. (586)

C) The RAI MDS assessment completed on a day in 2014, in regards to bowel incontinence, identified resident #001 as continent; the RAI MDS assessment completed six months later identified the resident as usually continent. The home's continence management program, RESI-10-04-01, dated November, 2013 stated that a continence assessment was to be completed with "any deterioration in continence level". A review of the resident`s paper and electronic chart identified that a continence assessment had not been completed for resident #001 when their continence level deteriorated. A member of the registered staff confirmed that no continence assessment had been completed for this resident. [s. 51. (2) (a)]

2. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

A) The RAI MDS assessment completed on a day in 2014, in regards to urinary incontinence, identified resident #001 as incontinent; the RAI MDS assessment completed six months later identified the resident as frequently incontinent. The resident's written plan of care last revised one month prior to the most recent assessment stated that the resident was occasionally incontinent of urine. The written plan of care did not accurately reflect the resident's current urinary status. This was confirmed with a member of the registered nursing staff.

B) The RAI MDS assessment completed on a day in 2014, in regards to bowel incontinence, identified resident #001 as continent; the MDS assessment completed six months later identified the resident as usually continent. The resident's written plan of care last revised one month prior to the second assessment stated that the resident was occasionally incontinent of bowel. The written plan of care did not accurately reflect the resident's current bowel status. This was confirmed with a member of the registered nursing staff. [s. 51. (2) (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, (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; and

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) The RAI MDS assessment completed on a day in 2014, identified that resident #012 was in moderate pain less than daily. This was a change from the previous assessment that was conducted three months earlier where the resident was not coded as being in pain. The home's pain management policy, RESI-10-03-01, dated March, 2014, stated that an indicator for completing a pain assessment would be if the resident had "scored on the RAI MDS assessment under section J as 1 (pain less than daily) or 2 (pain daily)"

and that a paper or electronic assessment tool be used. A pain assessment conducted within the three month period could not be located in the resident's health record. Interview with the RPN confirmed that the resident's pain had not been assessed with a clinically appropriate instrument specifically designed for pain. (539)

B) The resident`s RAI MDS assessment completed on a day in 2014 indicated that the resident experienced pain daily and that it was excruciating at times. Approximately seven weeks later, resident #003 was observed by the LTC Inspector to be restless and upset. The document the home referred to as the resident's "care plan" completed one month prior to this incident, indicated that the resident experienced pain. The resident's electronic Medical Administration Record (eMAR) indicated that the resident had received a pain medication to be administered routinely and as needed if routine pain medication was ineffective. Review of the resident's health records indicated that an assessment for pain using a clinically appropriate assessment instrument specifically designed for pain was not conducted. Interview with the RPN confirmed that the resident's pain had not been assessed with a clinically appropriate instrument specifically designed for pain when initial pain management interventions were not effective. (526)

C) Resident #008's RAI MDS completed on a day in 2014 indicated that the resident experienced moderate pain less than daily. Registered staff interviewed by LTC Inspector and progress notes indicated that the resident had been calling out with pain ten days later, during the night shift. The resident's eMAR indicated that the resident had received a medication for pain as needed and was received in addition to a regularly scheduled pain medication. The RPN stated that a pain assessment had not been completed using a clinically appropriate instrument specifically designed for pain when initial pain management interventions were not effective. (526)

A member of the registered staff confirmed that the home did not assess pain using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #10: 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 that was instituted or otherwise put in place was complied with.

The home's "Falls Prevention and Management Program" policy number RESI-10-02-01 last reviewed April 2013, directed staff to complete a post falls assessment within 24 hours of a fall.

Resident #003 was assessed as a high risk for falls using the Morse Falls Risk Assessment completed on a day in 2014 and four months later. Interview with a registered practical nurse (RPN) confirmed this. According to the resident's health record, resident #003 fell five times within a one month period that occurred between these two assessments. Review of the resident's health record indicated that post falls assessments had not been completed after these five falls for resident #003 according to the home's policy. The DOC confirmed this and stated that the home's policy had not been followed in that post falls assessments should have been completed after resident #003's five falls. [s. 8. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that precluded exit by a resident, including balconies and terraces, or doors that residents did not have access to were kept closed and locked.

On December 15, 2014, during the initial tour of the home at 1130 hours and 1145 hours, the back service door on the main floor was observed to be unlocked and there was no employee or delivery person in the area. An employee from the adjacent kitchen confirmed that the housekeeper should have ensured that the service door was locked. The Manager of Environmental Services was shown the unlocked door and confirmed that the door should be secured at all times. [s. 9. (1) 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where bed rails were used, a resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #006 was observed in bed with two half rails in the raised position on December 17, 2014. The resident's plan of care indicated that the resident used an assist rail in the up position for mobility and positioning. Review of the resident's health record indicated that resident #006 had not been assessed in their bed system in accordance with evidence-based practices, or with prevailing practices to minimize risk to the resident. During interview with the (LTC) Inspector, the Charge Nurse and DOC confirmed that where bed rails were used, resident #006 had not been assessed to minimize risk to the resident. (526)

B) Resident #001 was observed in bed with two assist rails in place on December 15, 2014. The resident's plan of care indicated that the resident used two assist rails in the up position for mobility and positioning. Review of the resident's health record indicated that resident #001 had not been assessed in their bed system in accordance with evidence-based practices, or with prevailing practices to minimize risk to the resident. During interview with the LTC Inspector, the Charge Nurse and DOC confirmed that where bed rails were used, resident #001 had not been assessed to minimize risk to the resident. (539)

C) Resident #008 was observed in bed with two quarter rails in the raised position on December 15, 2014. The resident's plan of care indicated that the resident used two assist rails in the up position for mobility. Review of the resident's health record indicated that resident #008 had not been assessed in their bed system in accordance with evidence-based practices, or with prevailing practices to minimize risk to the resident. During interview with the Long Term Care (LTC) Inspector, the Charge Nurse and DOC confirmed that where bed rails were used, resident #008 had not been assessed to minimize risk to the resident. [s. 15. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimeters.

On December 15, 2014 during inspection of the second floor of the home, the resident lounge adjacent to room 275 was observed. Three windows in the lounge area were observed to open to the outside, one to the ground and the other two to a roof top below. The openings of the three windows were measured at 12cm, 23 cm and 29 cm. The Executive Director reviewed the windows and confirmed that two of three windows had stoppers that allowed the window to open greater than 15 centimeters. [s. 16.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system was easily seen, accessed, and used by residents, staff and visitors at all times.

The document the home referred to as the "care plan" for resident #200 completed within three months of this inspection, indicated that the resident had a history of falls with fracture and directed staff to ensure that the resident's "call bell" was within reach. On December 15, 2014 the resident was observed in bed and the resident's call bell was noted to be hanging from the wall and laying on the floor between the wall and the head of the resident's bed. The resident's visual impairment prevented them from seeing the call bell.

The resident was observed by the LTC Inspector to attempt to find the call bell but was unable when LTC Inspector asked them to trigger it. The resident was able to trigger the alarm when the call bell was placed beside the resident. During interview, the resident stated that they used the call bell to alert staff to their need for assistance.

The home's "Communications" policy for "Nurse Call System" number RESI-08-02-01 last reviewed December 2002 indicated that staff "Ensures call bell at bedside is easily accessible to the resident at all times". During interview with LTC Inspector, personal support worker (PSW) and registered practical nurse (RPN) staff confirmed the resident used the call bell to ask for assistance and that that the call bell should be accessible to resident #200 according to their plan of care. [s. 17. (1) (a)]

WN #15: 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. (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).

Findings/Faits saillants :

1. The licensee has 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

Resident #006 had health conditions that caused disturbances in mobility and in mood. Progress notes indicated that the resident used the call bell frequently to ask for assistance. During interview resident #006 told the LTC Inspector that approximately one month ago, staff had threatened to take the call bell away because the resident had been using it so frequently. The resident stated that staff had taken their call bell away in that they placed it beside the resident but so that the resident could not reach it due to their health limitations. The resident stated that they had to yell for staff because they couldn't find or reach the bell. According to the resident, staff then threatened to close the resident's bedroom door on night shift because the resident was calling for assistance frequently.

The resident complained to the Charge Nurse but the resident told the LTC Inspector that they felt that the issue had not been resolved. On December 16, 2014, the LTC Inspector informed the Charge Nurse of resident #006's concerns. The Charge Nurse stated that they knew about these complaints and felt they were unfounded. The Charge nurse confirmed that the document the home referred to as the "care plan" dated November 9, 2014 indicated that the resident had "multiple unfounded complaints of staff". The Charge Nurse was unable to provide documentation of the investigation of the complaint and confirmed that they did not make notes of the resident's verbal complaints.

During interview with the LTC Inspector, the DOC stated that they had interviewed resident #006 on December 17, 2014 and concluded that they needed to investigate further in order to resolve the resident's complaint. The DOC and Administrator confirmed that the home should have documented verbal complaints that had not been resolved within 24 hours. [s. 101. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that where drugs were stored, that they were kept locked at all times, when not in use.

On December 15, 2014 inspector #539 observed a topical medication at resident #004's bedside. The PSW interviewed stated that the medication should not have been stored at the resident's bedside and should have been stored in a secure location when not in use. [s. 130. 1.]

WN #17: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a staff member who may be permitted by a member of the registered nursing staff to administer a topical medication had been trained by a member of the registered nursing staff in the administration of topical medications.

On December 19, 2014, during interview with the LTC Inspector, a PSW indicated that they administered topical medications to residents including resident #006, and that they had not been trained in the past ten years. Interview with resident #006 indicated that a PSW would normally apply a topical medication to them. The Charge Nurse confirmed that non registered staff who would not normally administer medications, were administering topical medications in the home. The Charge Nurse could not confirm that PSW staff had been trained to do so. [s. 131. (4)]

WN #18: 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. (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 residents had been offered immunizations against tetanus and diphtheria and pneumoccocus in accordance with the publicly funded immunization schedules posted on the Ministry website.

This information was confirmed by the health records and the RN. [s. 229. (10) 3.]

Issued on this 9th day of February, 2015

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

Original report signed by the inspector.