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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2016	2015_395613_0021	034495-15, 034056-15, 033032-15, 035135-15	Complaint

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 14 - 18, 2015

A concurrent Critical Incident Inspection #2015_395613_0022 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care (ED/DOC), Assistant Director of Care (ADOC), Director of Support Services, RAI Coordinator, Recreation Aide, Maintenance, Scheduler, Registered Staff (RN/RPN's), Personal Support Workers (PSW's), Resident and Family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

Inspector #613 reviewed multiple anonymous complaints regarding insufficient staffing in the home. The Inspector interviewed PSW #103, PSW #105, PSW #106, RPN #110 and PSW #111 who reported that the home was chronically under staffed especially during the evening shifts. At times, there were only three PSWs working on an evening shift and one of those PSWs was on modified duties and unable to push, pull or lift, leaving two PSWs to transfer, toilet and put all residents in to bed.

PSW #111 reported that the residents' showers and baths were not getting done sometimes on the evening shift, care was often hurried and rushed as at times there were only two PSWs to perform care for all of the residents. The residents that rang their call bell often had to wait longer to have their needs for assistance and care met. As reported by PSW #111 residents with responsive behaviours were not having their care needs met in a prompt manner to ensure their safety and the safety of other residents. PSW #111 reported that residents were not being provided thorough and quality care

due to the ongoing staffing issues.

The Inspector requested the home's staffing plan which the Executive Director/Director of Care (ED/DOC) was unable to provide. The ED/DOC reported that the home did not have one. The ED/DOC informed the Inspector that the current census was forty nine residents in the home and the planned staffing mix for the single level care area was a follows:

PSWs: 5 on day shift; 4 on evening shift; 2 on night shift (shifts are 8hrs)
RPNs: 1 on day shift; 1 on evening shift (shifts are 8hrs)
RNs: 1 on day shift and 1 on night shift (shifts are 12hrs)

Inspector #613 reviewed the staffing schedule from November 1, 2015 to December 12, 2015 and identified that the planned deployment of direct care staff was frequently not met.
Nov. 1/15 –short one PSW on day shift
Nov. 2/15 –short one PSW on evening shift
Nov. 11/15 – short one PSW on day shift
Nov.14/15 – short one PSW on evening shift
Nov. 15/15 – short one PSW on day and evening shift
Nov. 17/15 – short one PSW on day shift
Nov. 20/15 – short two PSWs on evening shift
Nov.30/15 – short one PSW on day shift
Dec. 2/15 –short two PSWs on evening shift
Dec. 3/15 – short one PSW on evening shift
Dec. 4/15 –short one PSW on evening shift
Dec. 5/15 – short one PSW on evening shift
Dec. 6/15 – short one PSW on evening shift
Dec.11/15 – short two PSWs on evening shift
Dec. 12/15 – short one PSW on evening shift
Dec. 15/15 – short one PSW on evening shift
Dec. 17/15 – short one PSW on evening shift

During an interview on December 16, 2015, Manager #107 reported that staffing issues were problematic on the evenings. Manager #107 informed the Inspector that there were three staff members on modified duties. One PSW on modified duties was assigned to the day shift and one PSW on modified duties was assigned to the evening shift. The PSW on modified duties was to ensure all oral care gets completed and if staff was

unable to complete residents baths on the evening shift, day staff were expected to complete on their shift.

During an interview on December 22, 2015, the ED/DOC also confirmed that evening shifts are problematic for staffing. The ED/DOC reported that the home had a scheduling problem at the beginning of December and at the end of November the home had to have agency staff work as there were no home staff that was available to work. The ED/EDOC reported they were in the process of recruiting and had job postings internally and externally. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulations, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for resident #001 who demonstrated responsive

behaviours (a) the behavioural triggers for the resident were identified, where possible (b) strategies were developed and implemented to respond to these behaviours where possible and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions were documented.

Inspector #613 reviewed several complaints received by the Director, identifying concerns about resident #001's responsive behaviours. The complaints identified that the home had a doctor's order for resident to receive constant care but the facility was not following the doctor's order. The complainants were concerned with resident #001's responsive behaviours.

Inspector #613 completed a health care record review for resident #001. Resident was admitted to the home and had cognitive impairment with responsive behaviours. A review of the progress notes on Mede care identified that resident #001 had displayed responsive behaviours on a daily basis since their admission. Resident had responsive behaviours towards others on a few occasions. A review of the MDS – RAPS identified that resident had the potential for their responsive behaviours to escalate without staff's redirection. The Inspector reviewed the home's four incident reports involving resident #001 and their responsive behaviours. All incident reports involved resident #001 wandering near other residents or their rooms and displaying responsive behaiovurs towards other residents residing in the home. There were no preventative interventions identified on the incident reports to prevent these types of incidences from reoccurring.

The home initiated a behavioural assessment, Client 7- Day Observation Record for resident #001 on their admission date, but the form was incomplete with many blank spaces. The Inspector could not locate any further behavioural assessments in the resident's health care records (paper or computer chart). The Inspector met with Manager #107 to determine if any further behavioural assessments had been completed on resident #001 since admission. Manager #107 provided the Inspector with another Client 7- Day Observation Record. The form was not in the resident's chart but rather in a separate file in the back room of the nurse's station. The Inspector reviewed the form and noted there were some blank documentation with no entries to identify the resident's behaviours for specific times. The documentation on the form was not coloured to show behaviour patterns. Inspector reviewed the progress notes in Mede care and there was no documentation to evaluate the Client 7- Day Observation Record documentation for behavioural patterns to identify reassessment and new strategies that could be implemented to minimize or manage resident #001's responsive behaviours. The

behavioural assessment had not been evaluated. There were no other behavioural assessments that were completed for this resident as confirmed by RN #113 and Manager #107.

The Inspector reviewed the resident's current care plan that was accessible to staff and the Inspector was unable to locate behavioural triggers that would notify staff when possible responsive behaviours would occur and that would identify to staff the appropriate interventions to implement. PSW #105 and PSW #106 confirmed to the Inspector that triggers were not identified in resident #001's care plan.

In November 2015, the home received a doctor's order to provide specific monitoring for resident #001's adjustment period to the home. Then again three days later, the home received a doctor's order to provide specific monitoring immediately. During an interview with Manager #107, they reported that the specific monitoring was implemented but management ended this intervention due to lack of funding at the end of November 2015. Manager #107 confirmed that a doctor's order was not received to discontinue this service. As well, Manager #107 reported they had not made a referral for high intensity needs funding from the Ministry of Health and Long Term Care for supplementary staffing. The Inspector reviewed the progress notes in Mede care and hand written notes by staff that had provided the specific monitoring and the notes identified that resident #001 continued to display responsive behaviours with the specific monitoring implemented.

The Inspector observed resident #001 at various times during the inspection and observed resident to have responsive behaviours towards other residents. Staff used communication techniques and redirection to guide resident #001 to their room. While resident was in their room, staff would get resident to participate in the same intervention repeatedly. Staff would then leave resident in their room and close the door. The inspector did not observe staff use any other intervention to respond to resident's responsive behaviours or refer to the plan of care.

During an interview on December 16, 2015, Manager #107 reported to the Inspector that Behavioural Supports Ontario (BSO) had only been in contact with the home via telephone conference and fax for consultations. The BSO had not been in the home to assess resident #001's responsive behaviours. The BSO had not provided any education or training to the staff in the home to assist with managing or minimizing resident #001's responsive behaviours.

During an interview on December 16, 2015, the ED/DOC reported that there had not been a family or staff interdisciplinary meeting to discuss resident #001's care plan in order to update resident #001's care plan. The ED/EDOC confirmed that resident #001's current care plan strategies were not effective in managing their responsive behaviours.

The Inspector reviewed the home's policy and procedure titled, 'Responsive Behaviour Management' policy #: VII-F-10.20 with a current revision dated January 2015. The policy states the needs of the resident will be met using an interdisciplinary approach to screening, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, and to determine the occurrence, frequency, and duration of responsive behaviour concerns. The procedure identified that registered staff were to evaluate the effectiveness of a planned intervention on the care plan that was addressing specific responsive behaviours, determine if the responsive behaviours were endangering other residents. Strategize with other members of interdisciplinary team to identify causes and triggers, identify in the plan of care any measures to identify level of risk (low, medium) or crisis triggers and the interdisciplinary team will work together to identify possible triggers for responsive behaviours based on the preliminary evidence based assessments. There was no documentation in the resident's plan of care to demonstrate that behavioural triggers were identified, ongoing and different strategies were developed and implemented to respond to resident #001's behaviours and that actions were taken to respond to resident's needs, including assessments, reassessments and different interventions attempted. [s. 53. (4)]

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 resident #001 that demonstrated responsive behaviours that the behavioural triggers for resident #001 are identified, strategies are developed and implemented to respond to these behaviours and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions that resident #001 responses are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the organized recreational and social activities program for the home under subsection 10 (1) of the Act. O. Reg. 79/10, s. 65 (1) provided assistance and support to permit resident #001 to participate in activities that may be of interest to them if they are not able to do so independently.

During an interview on December 15, 2015, the family member of resident #001 reported to the Inspector that the Activity department was not involved with resident #001 to provide activities that were of resident #001's interest. The family had requested that resident attend an activity of their past interest but resident #001 has not attended the activity. The family member felt that staff did not want to take resident to the activity programs and that staff always kept resident in their room with no activation. The family did not know of any activation that the resident had participated in.

Inspector #613 completed a health care record review for resident #001 and there was no documentation to identify that resident was receiving activation of their interests. The care plan identified that resident will attend activities of their interests.

On December 15, 2015, Inspector met with Recreation Aide #104. Recreation Aide #104 reported to the Inspector that one to one activation had not been provided to resident and that resident had not been brought to activities of their interest. On the same date, a short time later, Recreation Aide #104 reported to the Inspector that they had telephoned the Manager #114 who was not present at work for clarification regarding resident #001's participation in the recreational and social activities program. The Recreation Aide #104 reported that Activity staff had not been working with this resident. The Recreation Aide #104 reported that staff had on occasion asked resident #001 if they wished to attend an activity program but resident #001 had refused. The Recreation Aide #104 identified that Manager #114 had stated they had taken resident to a couple activities of their interest but resident did not stay long due to their cognitive impairment.

Inspector #613 requested the activation attendance records for resident #001. The Recreation Aide #104 was unable to provide the activation attendance records and reported to the Inspector that there was no documentation to show resident #001's participation in the recreational and social activities program. The Recreation Aide #104 could not provide an explanation as to why the recreational and social activities program did not provide assistance and support for resident #001 who demonstrated responsive behaviours.

During the inspection, the Inspector did not observe resident #001 participate in the recreational and social activities program nor observe the staff implement interventions identified in the care plan under the activity/interest focus. [s. 65. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the organized recreational and social activities program for the home, provide assistance and support to permit resident #001 to participate in activities that are of interest to them, to be implemented voluntarily.

WN #4: 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. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that that direct care staff received training in the techniques and approaches related to responsive behaviours.

During the inspection, Inspector #613 observed resident #001 display responsive behaviours towards staff and other residents. The staff used communication techniques and brought resident to their room to participate in an activity in an attempt to distract resident's attention. This technique was used repeatedly by the staff. The Inspector did not observe staff use different techniques or approaches to minimize or manage resident #001's responsive behaviours.

Inspector met with different staff members to inquire about their training. PSW #105, PSW #106 and RPN #110 all reported to the Inspector that they had not received training for caring for residents with dementia or techniques and approaches related to responsive behaviours.

On December 15, 2015, the Inspector requested the staff training records on managing responsive behaviours from Manager #107. Manager #107 was unable to provide the staff training records on responsive behaviours and confirmed education has not been provided to the direct care staff.

During an interview on December 16, 2015, the Executive Director/Director of Care (ED/DOC) reported that Behavioural Supports Ontario (BSO) had not been to the home to provide staff education. [s. 221. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that direct care staff receive training in the techniques and approaches related to responsive behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (2) Every licensee of a long-term care home shall ensure that the emergency plans for the home are in writing. O. Reg. 79/10, s. 230 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the emergency plan for loss of one or more essential services for the home was in writing.

A complaint was received by the Director identifying that the water in the home had been shut off for six hours in the resident home areas due to plumbing issues.

During an interview on December 15, 2015, Manager #102 reported to the Inspector that the water had been shut off on December 10, 2015 from approximately 12:00 pm to 4:00 pm but there had been the potential that the repair work would take six or more hours. Manager #102 reported that the three inch water main pipe branches off into a two inch L shape pipe and there was a leak at the joint. The water had to be shut off in all the resident home areas as there was no other shut off valves to isolate the water shut off to a specific resident home area wing. Manager #102 identified that a management planning meeting had occurred prior to the water shut off but there was no backup plan if the water shut off would have occurred for longer than six hours.

The Inspector requested the written plan and minutes from the management meeting. Manager #102 reported to the Inspector that there was no written plan or minutes from the meeting that all discussion had occurred verbally.

Inspector met with the Executive Director/Director of Care (ED/DOC) and requested the home's policy and emergency plan on loss of essential services such as water.

The ED/DOC reported that they did not have a copy of the management planning meeting minutes as no minutes were taken. The ED/DOC showed the Inspector the home's Emergency Plan binder. There was no policy in relation to the loss of essential service such as water. On the index page of the policy binder, it was written that the policy for flood/water damage was in the process of being determined. This policy was not completed and not currently in place. There was no policy for the loss of water. The emergency plan for loss of one or more essential service was not written. [s. 230. (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 emergency plan for loss of one or more essential services (water)was in writing, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001.

During an interview with Inspector #613 on December 15, 2015, resident #001's family member advised the Inspector that resident #001 had a device in place so that staff were aware when the resident leaves their bed. The device advises staff to check on resident #001 as they wandered and entered other resident's rooms.

During an interview on December 15, 2015, PSW #105 confirmed that resident had a device to notify staff when resident got out of bed and staff were aware to monitor residents whereabouts.

The Inspector met with Manager #107 who confirmed that the purpose of resident #001's device was to ensure that the resident did not wander into other resident's room. Manager #107 reported resident knew how to turn their device off.

A review of Resident #001's plan of care found no mention of the device that was in use. It was not documented in the plan of care that the device was in place to alert staff that the resident was out of bed or the potential to wander into other resident's rooms. The plan of care did not provide clear direction to the use of the device for staff and others who provided direct care to resident #001. [s. 6. (1) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview on December 15, 2015, the family member of resident #001 reported to the Inspector that resident #001 was not receiving their baths twice a week. The family member reported that staff had informed them that they did not know how to approach resident to gain permission to assist with their bath. The family member reported that staff were not trained to look after residents with a diagnosis of dementia.

Inspector #613 completed a health care record review for resident #001 and reviewed a form titled, 'Observation Record' that is completed by the Personal Support Worker assigned to the resident on their scheduled shift. The form identified from a time period of 15 days in December 2015, that resident #001 had received a bath only once. There was no documentation to identify that the resident had received additional baths, showers or full sponge baths during that time period.

PSW #105 and PSW #106 confirmed there was no other documentation to support resident #001 had received a bath twice per week.

The Inspector randomly reviewed two other resident's Observation Records and noted, resident #007 had received no baths for a time period of 15 days in December 2015. There was documentation for one date that identified that resident #007 had refused one bath. For another resident, resident #008, there was only documentation for receiving one bath during this same time period.

During an interview on December 18, 2015, Manager #107 confirmed that staff were expected to complete their role requirements on their scheduled shifts. The resident baths were to be done twice weekly. [s. 33. (1)]

Issued on this 3rd day of February, 2016

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

Original report signed by the inspector.