Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 6, 2020	2019_740621_0036	017463-19, 017515-19, 018237-19, 018431-19, 018486-19, 019537-19, 019644-19, 019737-19, 019914-19, 020848-19, 021695-19, 022429-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

JULIE KUORIKOSKI (621), DAVID SCHAEFER (757), DEBBIE WARPULA (577), HILARY ROCK (765), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 16 - 19, 2019.

The following intakes were inspected during this Critical Incident System (CIS) Inspection:
- One intake, related to alleged staff-to-resident neglect;
- One intake, related to improper skin and wound care;
- Two intakes, related to improper transfer care;
- One intake, related to improper wound care and medication management;
- One intake, related to improper care, associated with inaccessible call bells;
- Five intakes, related to resident-to-resident responsive behaviours, resulting in injury; and
- One intake, related to alleged staff-to-resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Managers (CMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The Inspector(s) also conducted a daily tour of the resident care areas; observed staff-to-resident, and resident-to-resident interactions; and reviewed the home's supporting documentation, including relevant health care records, reporting and investigation records, as well as specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **3 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	Légende 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. 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 that the home was equipped with a resident-staff communication and response system that, could be easily seen, accessed and used by residents, staff and visitors at all times.

During the inspection, over a specific number of times, on a specified day in December 2019, Inspector #759 observed resident #022 in a certain location of the home, with a particular communication device not visible.

Inspector #759 reviewed resident #022's current care plan, which included a specific intervention that required staff to remind the resident to utilize the identified communication device prior to attempting a specific activity, and that the communication device was to be accessible to the resident.

Together with Inspector #759, PSW #116 observed resident #022's in a certain location of the home and confirmed to the Inspector, that the identified communication device was not within reach of the resident, and proceeded to place it within their reach. [s. 17. (1)

(a)]

2. A Critical Incident System (CIS) report was received by the Director, on a specific day in September 2019, for an incident in which a specified number of residents had been without access to a particular communication device, over a specific shift on that day. The report identified that a Personal Support Worker (PSW) moved the communication devices from their usual location.

Inspector #765 reviewed the care plans and electronic health care records for resident #006, #007, #009, #010, #011, #021, and #023 that were current at the time of the incident. The records indicated that the identified residents required specified levels of staff assistance for a particular number and type of care activities; and these residents were to have their communication devices within reach, when they were engaged in a specified activity.

A review of the home’s investigation notes, indicated that Registered Practical Nurse (RPN) #129 thought someone had purposefully placed the communication devices in a specified location, in order to achieve a certain outcome.

Within the investigation file, the Inspector identified an email from Clinical Manager #117, which was directed to the RPN staff, which indicated that there were concerns regarding the issue of communication devices being inaccessible to residents.

During an interview with PSW #127, they indicated that they were the staff person who noticed certain communication devices that were not within reach of the named residents, during a specific shift, on the specified day, in September 2019.

During separate interviews with PSWs #112, #113, #124 and #127, as well as Registered Nurse (RN) #123, they confirmed to the Inspector that the identified communication device, was to be within reach of residents, when they were engaged in a specified activity.

Clinical Manager (CM) #117 confirmed that on the specified date in September 2019, the residents identified in the CIS report, should have had their communication devices within reach, but did not. [s. 17. (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 that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #2: 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 homes written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Neglect is defined in Ontario Regulation 79/10, s.5, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a CIS report to the Director on a specific date in September 2019, which alleged that resident #022 had been neglected by PSW #121 and RPN #120 during the night shift on the same date. The report indicated that RPN #111, reported to Clinical Manager #122, that resident #022 had been found on their subsequent shift, in a certain condition.

Inspector #759 interviewed PSW #114, who reported that at the time of the incident, they had found resident #022 in their room, in a certain condition.

During an interview with PSW #110, they reported to the Inspector that unit staff were to monitor every resident during their shift, at specified intervals. They further reported that, staff were to provide residents with a specific type of care, on a certain shift, during a particular period of time.

Inspector #759 reviewed resident #022's care plan, current at the time of the incident, which indicated that this resident was to have a certain care activity completed by staff and required a specific level of staff assistance to complete this care activity.

Inspector #759 reviewed the home's investigation notes, which identified video footage had been reviewed by Clinical Manager #122, which identified that RPN #120 and PSW #121 had not entered resident #022's room over a specified period of time, to complete the identified care activity.

A review of the home's policy titled "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program", last updated June 2019, identified that "Extendicare has a zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated".

During an interview with Clinical Manager (CM) #122, they confirmed to the Inspector, that at the time of the incident, PSW #121 and RPN #120 had neglected resident #002, by not checking on them over specified time intervals, and not providing the required care. Further, CM #122 identified that as a consequence, the home failed to comply with their Zero Tolerance of Resident Abuse and Neglect policy. [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 the homes written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A CIS report was received by the Director on a day in September 2019, in which it was alleged that resident #004 had not been provided care as ordered for altered skin integrity and medication management of a specific condition.

A review of resident #004's health care records was conducted by Inspector #196, and a physician's order was identified from a particular date in September 2019, which prescribed a specific treatment for this resident. On review of the electronic Medication Administration Records (eMAR) and electronic Treatment Administration Records (eTAR), the Inspector further identified missing documentation during the time period that the medication was to be administered, for the specified area of altered skin integrity.

During an interview with RPN #146, they reported to Inspector #196 that the identified medication was to be recorded as administered on the eMAR/eTAR by the registered staff. RPN #146 confirmed there was missing documentation for a specific number of administration times, over a specified time period in September 2019.

During an interview with Clinical Manager #139, they reported the identified medication was included on the eTAR and that staff had not checked it. The Clinical Manager confirmed to the Inspector that the medication had not been applied as ordered to resident #004, for a specific number of administration times, over a specified time period in September 2019. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director on a specific date and time in September 2019, regarding an incident which occurred one day earlier, involving suspected improper care of resident #003, which resulted in a risk of harm to the resident. The CIS report indicated that PSW #103 witnessed the suspected improper care, and reported the incident internally to Clinical Manager (CM) #101 on the day of the incident. The report

also identified that CM #101 received the communication on the next day, at a specific time, but had not submitted an initial report to the Director until later that day.

Another CIS report was submitted to the Director on a specified date and time in October 2019, regarding an incident which occurred one day earlier, involving suspected improper care of resident #012, which resulted in a risk of harm to the resident. The CIS report indicated that PSW #100 witnessed the suspected improper care, and reported the incident internally to CM #101 that day. The report indicated that CM #101 had not read the communication until they arrived at work the following day, and then did not submit an initial report to the Director until later that day.

A review of the home's policy "Zero Tolerance of Resident Abuse and Neglect – RC-02-01-02", last updated June 2019, stated "Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager, or if unavailable, to the most senior Supervisor on shift at that time" and added that "In Ontario, in addition to the above, anyone who suspects or witnesses abuse, incompetent care or treatment of a resident … that causes or may cause harm to a resident is required to contact the Ministry of Long Term Care (Director)". Additionally, Appendix 2 of the policy stated that "Section 24(1) of the LTCHA requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur". The appendix included "Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident" as an incident which would require an immediate report.

A review of the home's policy "Critical Incident Reporting (ON) – RC-09-01-06", last updated June 2019, stated that "Mandatory reporting under the LTCHA (Ontario): Section 24(1) of the LTCHA requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur" and went on to include "Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident" as an incident which would require an immediate report.

During an interview with PSW #100, they indicated that they had internally reported the incident right away to CM #101 and also verbally reported the incident to RPN #118.

During an interview with RPN #118, they indicated that when they had received report on the incident of suspected improper care of resident #012 from PSW #100, they did not

report the incident to the Director, the RN on shift, or the Clinical Manager, stating “[They] told me that [they] already sent an e-mail to the manager”. RPN #118 indicated that during their training on reporting requirements, they had been trained to communicate the incident to their manager and to write a report to the RN.

During an interview with CM #100, they stated that suspected improper care was to be reported to the Director immediately. The CM indicated that all registered staff had received training on the duty to make mandatory reports during the summer of 2019, and stated that staff would have to be re-educated on how to report, if the Clinical Manager was not present in the home. The CM indicated that the expectation for staff who suspected improper care had occurred, and where the suspicion occurred outside of regular business hours, was to report to the RN, and then the RN would be expected to submit the initial report to the Director using the after-hours emergency contact number.

During an interview with the Administrator, they indicated that when a PSW suspected that improper care had occurred, the home’s expectation was that the PSW would report the suspicion to the registered staff. The Administrator explained that if the incident occurred during business hours, the Clinical Manager would submit the initial report to the Director. The Administrator went on to explain that if the incident occurred outside of regular business hours, the registered staff would be expected to contact the Manager on-call and decide whether to contact the after-hours emergency contact number. [s. 24. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone, had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was received by the Director on a day in October 2019, which identified that on an earlier date in September 2019, unit staff reported to Clinical Manager (CM) #122 that resident #014 had injuries to specific locations of their body, which had been caused by a visitor. The CIS report further identified that the CM had informed the resident's substitute decision maker (SDM) on the same day of the alleged abuse, and that a report to the Ministry of Long-Term Care would be made.

During an interview with CM #122, they confirmed to Inspector #621 that, unit staff had reported injury of resident #014 on the specified date in September 2019, and following discussion of the incident with former DOC #146 and the Administrator, that a decision was made to handle the incident internally, as it was later identified through interviews that staff only suspected abuse by the named visitor, and had not actually witnessed the abuse. On review of the legislative requirements with the Inspector, CM #122 confirmed that the home had not reported the suspicions of abuse towards resident #014, by anyone, immediately, as required. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #003.

A CIS report was submitted to the Director regarding an incident which occurred on a date in September 2019, concerning an unsafe transfer of resident #003. The report described that resident #003 was transferred by PSW #104 without the assistance of a second staff member. The CIS report indicated that the PSW admitted to completing the transfer independently.

A review of the home's policy "Safe Lifting with Care Program – LP-01-01-01", last updated August 2017, indicated that two trained staff were required at all times when performing a mechanical lift transfer. This policy defined a mechanical lift as any mechanical device which supports part or all of a resident's weight during the transfer process and includes floor lifts, ceiling lifts, sit-to-stand lifts, and tub lifts.

A review of resident #003's care plan at the time of the incident indicated that the resident required two staff assistance with transfers, when using a mechanical lift, for a certain care activity.

A review of the home's notes from the internal investigation into the incident, identified that when PSW #104 was asked why they had not asked for assistance from a second staff member to complete the transfer, PSW #104 stated "I don't have a reason" and "No one uses two people. Even people from other floors do not take a second person".

An internal investigation note, from a specific date in September 2019, documented a conversation between resident #003 and CM #101, in which resident #003 confirmed that they were transferred on the day of the incident by only one staff member, adding that there were usually two staff members present to assist.

During an interview with PSW #104, they admitted that they completed the transfer independently, stating that they got busy that day and didn't want to wait for someone to assist them. The PSW stated they were aware at the time that the transfer, using a specific safety device, was supposed to be completed with two staff members.

During an interview with CM #101, they confirmed that all mechanical lift transfers were to be completed with two staff members. [s. 36.]

2. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #012.

A CIS report was submitted to the Director regarding an incident which occurred on a specific date in October 2019, concerning an unsafe transfer of resident #012, by PSW #102.

A review of resident #012's care plan at the time of the incident indicated that the resident required transfer using a mechanical lift, as needed, with two staff members to assist.

A review of the home's internal investigation, identified PSW #102 admitted to completing transfer of the resident independently. Further, documentation identified that when PSW #100 had attempted to assist with the transfer on the day the unsafe transfer occurred, PSW #102 stated "I told her I can do [them] myself".

During an interview with PSW #102, they stated that the PSW staff were behind with their work that day and had instructed their co-worker PSW #100 to go to the dining room. PSW #102 admitted that they should not have completed the transfer with just one person.

During an interview with CM #101, they confirmed that all mechanical lift transfers were to be completed with two staff members.

CO #003 was issued during inspection #2019_768693_0021 pursuant to O. Reg. 79/10, s. 36, with a compliance due date of November 4, 2019. As the compliance date was not yet due at the time of this inspection, these findings will be issued as a WN to further support the order. [s. 36.]

WN #7: 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 each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

A CIS report was submitted to the Director, on a specific date in October 2019, for an incident, regarding resident-to-resident abuse which occurred on earlier date in October 2019, between resident's #016 and #026. The CIS report identified that resident #026 was to have a particular type of care provided; however, at the time of the incident, the required care did not occur.

Inspector #693 reviewed health record documentation for resident #026, and a prescriber's order from a specific date in September 2019, indicated that resident #026 was to have a specific type care completed by staff, over a specified period of time. In addition, another order from a specific date in October 2019, indicated that the specified care activity for resident #026, was to continue.

A review of resident #026's care plan with a specific focus, effective on a certain date in September 2019, identified an intervention which indicated, resident #026 was to have a specific type care activity provided by staff, over a specified period of time.

Inspector #693 reviewed the home’s investigation notes, which identified that PSW #126 was the assigned the specified care activity with resident #026, on a particular shift in October 2019. The notes further indicated that before going on their break, PSW #126 failed to hand-off the specified care responsibilities to another staff member for this resident.

During an interview with PSW #126, they confirmed that during the identified shift on a specific date in October 2019, they were responsible for providing a specific type of care activity with resident #026. PSW #126 stated that the resident’s plan of care indicated that resident #026 was supposed to have this specified care activity provided over a certain period of time. The PSW further stated that they informed a certain number of staff that they were leaving the unit at a certain time to complete another activity, and only found out after that something happened between resident #026 and another resident. PSW #126 indicated that after the altercation between resident #026, and another resident, CM #117 informed them that when assigned to provide a certain care activity with resident #026, and before leaving the resident, they were to report directly to one staff member, and ensure that staff member continued to provide the care activity with resident #026 in their absence.

Inspector #693 reviewed the home's policy titled “Mental Health and Responsive Behaviours-HRM, LTC 3-5", approved in July 2019. The home’s policy, included an additional policy, titled, "Responsive Behaviours, RC-17-01-04", which indicated that the home was to implement and evaluate strategies and interventions to prevent, minimize and address responsive behaviours. In addition, the policy indicated that care staff were to be familiar with the residents' plans of care, the specific interventions related to behaviours and be consistent in the application and implementation of these interventions.

During an interview with CM #117, they indicated that on the day of the incident in October 2019, PSW #126 was assigned to provide a particular care activity with resident #026. CM #117 stated that this PSW left the resident before ensuring that another specific staff member replaced them, and during that time, an altercation occurred between resident #026 and resident #016. CM #117 indicated that the specific care intervention for resident #026 was not implemented at the time of the incident, and if it had been implemented, the resident-to-resident abuse, involving resident #026 and resident #016 would not have occurred.

CO #001 was issued during inspection #2019_671684_0035 pursuant to the Ontario

Regulation 79/10, s. 53. (4) with a compliance due date of November 29, 2019. As the compliance date was not yet due at the time of this critical incident, this finding will be issued as a WN to further support the order. [s. 53. (4) (b)]

Issued on this 9th day of January, 2020

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

Original report signed by the inspector.