Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Oct 3, 2019	2019_643111_0018	000631-18, 004633-18, 024991-18, 004814-19, 010340-19, 013524-19, 014162-19, 015679-19	Complaint

Licensee/Titulaire de permis

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

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

Thorntonview
186 Thornton Road South OSHAWA ON L1J 5Y2

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

LYNDA BROWN (111)

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): September 4-6, 9-13 and 16-18, 2019.

There were eight complaints inspected concurrently during this inspection as follows:
-Log #014162-19 related to responsive behaviours.
-Log #013524-19 related to responsive behaviours.
-Log #004814-19 related to bathing and continence care.
-Log #015679-19 related to alleged resident to resident abuse.
-Log #000631-18 related to complaints and alleged abuse of a resident.
-Log #024991-18 related to complaints, alleged staff to resident improper care, nutrition and hydration, skin and wound management and falls management.
-Log #004633-18 related to transfers.
-Log #010340-19 related to continence and bowel management, complaints and plan of care.

A Written Notification and Voluntary Plan of Correction related to LTCHA,2007, c.8, s. 20(1), was identified in this inspection and has been issued in Inspection Report 2019_815623_0014, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Services Coordinator (RSC), Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, families, Behavioural Support Ontario (BSO) staff and RAI Coordinator (RAI).

During the course of the inspection, the inspector reviewed resident health records, reviewed complaints and investigations, reviewed admission agreements, observed care and dining room service and reviewed the following policies: Infection, Prevention and Control, Continence Care, Resident Safety-Consumption of cannabis and Complaints.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **5 WN(s)**
- **4 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 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 :

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

Related to Log #010340-19:

A complaint was received by the Director on a specified date, regarding care not provided by staff to resident #016. The complaint indicated the Director of Care (DOC) and the Executive Director (ED) were notified of the care concerns on specified dates. The complaint letter indicated the resident was having a symptom that was not being treated in a timely manner.

Review of the progress notes of resident #016 by Inspector #111, during a specified time period, indicated the resident was having the symptom a number of times and were not treated in a timely manner. On a specified date, during the resident's annual care conference, the SDM expressed concerns that they were reporting the resident's symptoms and that they were not being treated in a timely manner. On a specified date, a second care conference was held where the SDM again reported concerns related to the resident's ongoing symptom. The DOC indicated the resident was to their toileting and continence care plan revised and a new treatment was ordered as a result.

Observation of resident #016 on a specified date and time, by Inspector #111, indicated the resident had a lingering offensive odour noted.

Review of the current written plan of care for resident #016 by Inspector #111, indicated under toileting, the resident was incontinent, was unable to self-toilet and had a specified diagnosis. The resident required assistance of two staff for all continence care needs. The plan of care also indicated the resident did not require a toileting program and the PSWs were to report to the nurse regarding specified symptoms.

During separate interviews with PSW #122, #123 and #125 by Inspector #111, they confirmed that resident #016 was incontinent, required two staff to assist with toileting and was provided a specified toileting schedule. The PSWs confirmed for a specified time period, the resident had not been provided with any toileting/incontinence care.

During an interview with the DOC by Inspector #111, they indicated awareness that resident #016 was at risk for developing the recurring symptom, they had received

complaints from the SDM of resident #016 regarding the frequent symptom and treatment not being provided in a timely manner. The DOC indicated they were not aware that the resident's plan of care did not provide clear direction to staff regarding the specified symptom and their expectation was, that assessment and treatment of the symptom was to be provided in a timely manner. The DOC was not aware of the factors surrounding the delay in treatment. The DOC confirmed the plan of care also did not provide clear direction to staff providing direct care to the resident, related to continence care needs.

The licensee failed to ensure that resident #016's plan of care, provided clear direction to staff and others who provided direct care to the resident related to a symptom to ensure treatment was provided in a timely manner and related to continence care needs.

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 plan of care provides clear directions to staff and others who provide direct care to residents, specifically related to continence care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure where the Act or this Regulation requires the licensee of a

long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy, that is in accordance with applicable requirements under the Act, is complied with.

In accordance with O.Reg. 79/10, s. 100, every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101 of O.Reg. 79/10.

In accordance with LTCHA, 2007, c.8, s.21, every licensee shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

Review of the home's Complaint Management policy (ADMIN3-010.01) reviewed August 2019 indicated, if concerns cannot be resolved immediately at point-of-service, the individual who is first aware of a concern will initiate the Client Service Response (CSR) Form. A copy of the initial form will forwarded to the Executive Director. Upon receipt of a formal letter of complaint or concern (either hard copy or electronic format), the complaint is acknowledged and the complainant is thanked for their feedback immediately, if in person or by telephone. Where the complaint alleges harm or risk of harm to one or more residents, an investigation shall commence immediately. The CSR form will be completed in full and all actions taken during the investigation will be documented. The CSR form is then filed in the complaints management binder. The ED /designate will initiate an investigation and follow applicable or jurisdictional reporting requirements.

Related to Log #000631-18:

A complaint was received by the Director on a specified date, from a family member of resident #017 alleging abuse by someone other than staff or residents and the allegation was reported to the Executive Director (ED).

Review of the complaint binder over a specified period, had no documented complaints received from the family of resident #017 relating to allegations of abuse of the resident by anyone.

Review of the progress notes for resident #017 during a specified period, had no documented complaints related to alleged abuse by anyone.

During an interview with the ED by Inspector #111, they initially indicated they were not

aware of any verbal or written complaints alleging abuse of resident #017 by anyone, during a specified period. The ED later indicated they had received a verbal complaint from the family of resident #017 alleging abuse by someone other than another resident or staff, that was received at a different specified date. The ED provided the Inspector with a copy of a written complaint that was received by the ED on a specified date, from a family member of resident #017, regarding the allegation. The ED confirmed they did not complete the CSR form to indicate the complaint was received on the specified date, to indicate an investigation was completed, or any actions that were taken, as per their policy.

2. Related to Log # 010340-19:

A written complaint letter was received by the Director on a specified date, regarding continence care not provided by staff, to resident #016. The written complaint indicated the DOC and the ED were notified of the care concerns on specified dates.

During an interview with the family member of resident #016 by Inspector #111, they indicated they were the resident's SDM. The SDM indicated they reported their concerns on more than one occasion to the DOC and ED, which included concerns with a symptom with a delay in treatment, improper continence care and their concerns were not resolved.

Review of the progress notes for resident #016 on specified dates, confirmed the SDM had reported their concerns to the ED and DOC.

Review of resident #016's electronic Treatment Administration Record (e-TAR) for a specified period, indicated the e-TAR was updated after the last complaint was received and indicated the RPN was to frequently monitor each shift, that the resident was provided continence care to decrease a specified diagnosis.

Review of the complaints management binder for a specified period indicated there was no documented evidence of any verbal or written complaints received by the SDM of resident #016.

During an interview with the ED by Inspector #111, indicated the DOC had received a complaint from the family of resident #016. The ED confirmed the complaints policy was not complied with, related to the complaints received by the family of resident #016, as the complaints were not indicated in the complaint management binder to indicate when

the complaints were received, the results of the investigation and when a response was provided to the complainant.

During an interview with the DOC by Inspector #111, they indicated they received a verbal concern from the SDM of resident #016 on a specified date, regarding concerns with an ongoing symptom that was not treated in a timely manner and continence care not provided. The DOC indicated the former ADOC also received a written complaint from the SDM on a specified date, regarding the same concerns. The DOC indicated they investigated the complaint items and responded in writing the complainant on a specified date. The DOC confirmed the home's complaints policy was not complied with as the complaints were not indicated in the complaint management binder to indicate, when the complaints were received, when the investigation occurred, the results of the investigation and whether the complaint was determined to be founded or unfounded and the reasons for their decision. The DOC also confirmed that the actions identified in the response to the complainant for resident #016, were not implemented.

The licensee failed to ensure a documented record was kept in the home that included the nature of each verbal or written complaint, the dates the complaints were received, the type of actions taken to resolve the complaint, the final resolution, and every date on which a response was provided to the complainant for resident #016 and #017.

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 licensee's complaint policy is complied with, to be implemented voluntarily.

WN #3: 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,
(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).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

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

Related to Log #010340-19:

A complaint was received by the Director on a specified date, from the family of resident #016. The complaint indicated resident #016 was not provided proper continence care.

Review of the health care record for resident #016 indicated the resident was admitted with a history of specified diagnosis.

Review of the current written plan of care for resident #016, related to continence care indicated the resident was incontinent and required staff assistance, as the resident was unable to complete the task independently. The interventions indicated the resident was not toileted and required the use of incontinence care products, as specified on the incontinence list.

Review of resident #016's admission assessment for plan of care, indicated the resident was continent of bowel and bladder and required one to two staff assistance for toileting. A continence diary assessment was also completed on admission and indicated the resident was to be toileted at specified time periods on specified shifts. There were no other continence assessments completed, despite the resident having a change in continence care needs, as per the practice in the home.

Review of the progress notes for resident #016 during a specified period, indicated on a specified date, during the annual care conference, the SDM of resident #016 had expressed concerns regarding the resident not receiving appropriate continence care. The note indicated the care plan was updated to reflect the changes to continence care needs. On a specified, a second care conference was held, and the SDM again expressed concerns around continence care not provided based on the residents assessed need. The DOC notified the SDM that the resident would be provided a toileting program and increased continence care. The following day, the e-TAR was updated to remind nursing staff to frequently check during their shift that the resident received continence care. There was no documented evidence the care plan was updated to reflect the changes to continence care.

An admission assessment for plan of care and a three day diary was completed for resident #016, upon admission on a specified date. Those assessments indicated the resident was continent of bowel and bladder and required staff assistance with toileting at specified intervals. A continence assessment was completed on admission and indicated the resident was incontinent and required an incontinence product. There was no indication related to toileting. There were no other continence assessments completed.

During separate interviews with of PSW #122, #123 and #124 by Inspector #111, all indicated resident #016 was incontinent of bowel and bladder, required staff assistance with toileting at specified times and also used an incontinence product.

During an interview with RPN #125 (agency) by Inspector #111, they indicated that they were unfamiliar with resident #016 and was not aware that they were to be monitoring that the resident's incontinence product was being changed frequently during their shift, as per the eTAR.

During an interview with the DOC by Inspector #111, they indicated they had met with the SDM of resident #016 regarding concerns with a frequent specified diagnosis and continence care not provided. The DOC indicated they also received a written complaint from the SDM regarding the same issue on a specified date. The DOC indicated the practice in the home when a resident's continence care and toileting needs changed, was that nursing staff were to complete specified continence assessments and update the care plan based on the results of the assessments. The DOC confirmed that resident #016 did not having any continence assessments completed since admission, the care plan was also not updated, despite the resident having changes in continence care and

as discussed with the family at the care conferences.

The licensee has failed to ensure that resident #016 who is incontinent, had an individualized plan of care to promote and manage bowel and bladder continence based on an assessment and that the plan was implemented as the resident did not receive an updated assessment as per the home's policy, the plan of care was not updated to promote and manage bowel and bladder continence. [s. 51. (2) (b)]

2. The licensee has failed to ensure the resident who was also unable to toilet independently, received assistance from staff to manage and maintain continence.

Related to Log #010340-19:

A complaint was received by the Director on May 21, 2019 from the family of resident #016. The complaint indicated resident #016 was not provided proper toileting/continence care.

Review of the current written plan of care for resident #016 related to continence care, indicated the resident required staff assistance with toileting, as the resident was unable to complete the task safely and independently. The plan of care also indicated the resident did not require a toileting program and was incontinence of bladder and bowel, used an incontinence product as indicated on a specified incontinence product list.

Review of the specified incontinence product list indicated, resident #016 was assigned a specified type and amount of incontinence products each day.

Observation of the resident on a specified date and time, indicated the resident was incontinent and unable to toilet them self independently. The resident had a lingering offensive odour noted. Observation of the resident's bathroom indicated none of the resident's allotted incontinence products had been used.

Review of the electronic Treatment Administration Record for resident #016 for a specified period, indicated the nurse was to monitor that the resident's incontinence product was being changed frequently every shift.

During separate interviews with of PSW #122, #123 and #124 by Inspector #111, on a specified date and time, all indicated resident #016 required two staff assistance with toileting and continence care and was to be provided at specified times during their shift.

The PSWs also indicated the resident had only received continence care by the previous shift and had not provided the resident with continence care for a specified period of time.

During an interview with RPN #125 (agency) by Inspector #111, they indicated that they were unfamiliar with resident #016 and was not aware that they were to be monitoring frequently during their shift, to ensure that the resident's continence care was being provided.

During an interview with the DOC by Inspector #111, they indicated awareness of resident #016 having an ongoing specified diagnosis, the SDM had expressed concerns on more than one occasion regarding the ongoing specified diagnosis and continence care not provided. The DOC confirmed the resident's plan of care had not been updated to ensure the continence care concerns were identified. The DOC was unaware that resident #016 had not received continence care on a specified date, for a specified period of time.

The licensee has failed to ensure that resident #016, who was also unable to toilet independently, received assistance from staff to manage and maintain continence as the resident did not receive assistance from staff to be toileted or provided continence care for a specified period of time on a specified date.

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 resident who is incontinent, and an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and the plan was implemented; to ensure the resident who was also unable to toilet independently, received assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #4: 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 :

The licensee has failed to ensure that the behavioural triggers had been identified for the resident demonstrating responsive behaviour where possible and strategies had been developed and implemented to respond to the resident demonstrating the responsive behaviours, where possible.

Related to Log #013524-19:

An anonymous complaint was received by the Director on a specified date, alleging resident #002 was abusive towards specified residents.

Related to Log #014162-19:

A second anonymous complaint was received by the Director on a specified date, alleging resident #002 was abusive towards specified residents.

Review of the progress notes for resident #002 during a specified period, indicated the resident demonstrated specified responsive behaviours towards staff and residents. There were also specified triggers. The progress notes indicated there were concerns expressed by resident #002 on specified dates, regarding an unidentified resident, which resulted in specified responsive behaviours by the resident. On a specified date, the resident's roommate was expressing concerns with resident #002 related to responsive behaviours. The resident was assessed by BSO RPN on a specified date for escalating responsive behaviours towards staff only and identified specified triggers and strategies to manage the responsive behaviours.

Review of the written plan of care for resident #002 indicated the resident demonstrated specified responsive behaviours to residents and staff and included specified triggers and interventions.There was no indication of specified responsive behaviours towards specified residents, triggers or any interventions to be implemented.

During an interview with the Behavioural Support Ontario (BSO) RPN #100 by Inspector #111, they indicated resident #002 was not currently being monitored by BSO and was only aware of specified responsive behaviours demonstrated by the resident towards staff.

During an interview with PSW #108 by Inspector #111, they indicated they were familiar with resident #002 and were aware of the resident demonstrating specified responsive behaviours towards staff. The PSW indicated resident #002 had also demonstrated specified responsive behaviours, towards specified residents and identified a specified interventions that was used to manage the behaviour. The PSW indicated the resident's included resident #005, #006, #007, #008 and resident #010. The PSW indicated specified triggers and interventions used for resident #002 when the resident demonstrated the responsive behaviours towards those residents.

During an interview with Resident Services Coordinator (RSC) by Inspector #111, they indicated they completed any resident room transfer requests and confirmed awareness that they had completed several internal transfer requests (for resident #005, #006, #007 and #008) as a result of resident #002's responsive behaviours. The RSC indicated resident #002 was currently awaiting an internal transfer to another unit with private accommodation.

During an interview with the DOC by Inspector #111, they indicated awareness of verbal complaints from the family of resident #007 regarding resident #002's responsive behaviours and a specified intervention that was implemented as a result. The DOC indicated they also received complaints from resident #002 regarding resident #008 and a specified intervention was implemented for resident #008. The DOC was not aware that the residents plan of care did not indicate responsive behaviours that were demonstrated towards specified residents or strategies that were to be used to manage the responsive behaviour.

During an interview with the ED by Inspector #111, they indicated they had received a verbal complaint from resident #002 regarding resident #010 and a verbal complaint from

the family of resident #010 regarding alleging abuse by resident #002 towards resident #010. The ED indicated the home had implemented a specified strategy to manage resident #002's responsive behaviours towards specified residents (#006, #007, #008 and #009) and had discussions with both resident #002 and the residents SDM regarding the residents responsive behaviours towards specified residents. The ED indicated they offered a specified strategy to resident #002 to remove one of the triggers, but the strategy was refused at that time by the resident and family, for a specified reason. The ED indicated the resident was currently on the internal wait list for an internal transfer which would remove the triggers for the specified responsive behaviour and an additional strategy was being used.

The licensee has failed to ensure that resident #002 who was demonstrating responsive behaviours towards specified residents, that the behavioural triggers had been identified and strategies were developed and implemented to respond to the resident's responsive behaviours, where possible.

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 behavioural triggers have been identified for the resident demonstrating responsive behaviours where possible, and strategies have been developed and implemented to respond to the resident demonstrating the responsive behaviours, where possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

s. 103. (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director. O. Reg. 79/10, s. 103 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a copy of a written complaint that was received, relating to a matter that the licensee reports (or reported) to the Director under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant. The licensee also failed to submit a report to the Director of the response the licensee made to the complainant immediately upon completing the licensee's investigation into the complaint.

Note: Section 24(1) of the Act
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: Misuse or misappropriation of a resident's money.

Related to Log #000631-18:

A written complaint was received by the ED on a specified date, from a family member of resident #017 alleging abuse of resident #017, by someone other than another resident or staff.

During an interview with the ED by Inspector #111, they confirmed they received a written complaint by a family member of resident #017 on a specified date, alleging resident #017 was being abused by someone other than another resident or staff. The ED indicated they reported the allegation to the police but did not report the allegation to the Director or provided the Director a copy of the response to the complainant.

The ED received a written complaint alleging abuse of resident #017 on a specified date, the allegation was not reported to the Director and there was no response provided to the Director.

Issued on this 3rd day of October, 2019

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

Original report signed by the inspector.