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3350-Op LASER 20-01 (COS)

14 May 20

Distribution List

OP LASER – JTFC OBSERVATIONS IN
LONG TERM CARE FACILITIES IN ONTARIO

References: A. Letter: Ontario Request for Assistance in Provincial Long Term Care Facilities, Fed Min PS Blair to Ont SOLGEN Jones, 24 Apr 20; and
B. 3350-1 (J33) JTF-LR Task Order 003 - JTFC Op LASER 20-01, 26 Apr 20.

1. Sir, as auth at Ref A and directed at Ref B, JTFC has employed Augmented Civilian Care (ACC) teams, since 28 Apr 20, in five Province of Ontario-prioritized Long Term Care Facilities (LTCF) that were in urgent and immediate need of personnel to provide humanitarian relief and medical support.

2. Since arrival, and with the benefit of two weeks of observation, CAF ACC have identified a number of medical professional and technical issues present at the five LTCF. From a command and medical perspective, challenges were expected at these facilities given the severe deficiencies and shortfalls that existed/exist at the provincially-prioritized assignments; the CAF was meant to go to locations with the greatest need of our support. This is a reflection of the conditions at those distressed locations. Consequently, issues and challenges have been collated and consolidated in medical reporting in the key areas of Standards and Quality of Medical Care. Annexes A-E provide detail by individual LTCF. The purpose of this letter is to ensure that these observations do not go unnoticed by our chain of command, the Province of Ontario, and most importantly at the individual LTCF where efforts are currently underway in an open, transparent and collaborative manner at the local level between each LTCF and ACC to aid in recovery by addressing the specific areas of observation.

3. Nothing in this letter is meant to encroach upon the purview of the CAF Surgeon General, the established relationship between that office and the Chief Medical Officer of Health for Ontario, or the formal and informal connections by the CFHS and its offices, with those medical and professional Colleges and Associations that represent the medical professionals and health care capabilities within the Ontario health care system. Rather, this is meant to compliment that discussion by ensuring a command awareness on these issues so as to support the Surgeon General, the CFHS and our CAF medical and non-medical general duty personnel as they execute daily tasks as an ACC team in this unexpected and difficult operating environment.

4. The Province of Ontario, and its Incident Management System (IMS) responsible to the Command Table and is responsible for dealing with the COVID crisis, co-chaired by the Provincial Deputy Ministers (DM) for both Health and for Long-Term Care, respectively, are aware that CAF ACC teams have made observations with Standards and Quality of Medical Care. Informally, key figures in the IMS understand the general themes of our observations but have not been privileged with specifics or detail. We have sought to make observations that are strictly factual in nature and are not meant to assess or pass judgment on LTCF leadership or staffs. From the perspective of our medical and non-medical personnel in-situ, however, the observations are sufficiently serious in nature to warrant them also being shared with the Province of Ontario, given that the CAF is responding to their RFA and LTCF fall under the Province's authority. I believe that this is best done under the Surgeon General's purview, and JTFC can enable that via our Regional Surgeon who has established links with the Provincial IMS Lead and Operations Head. Additionally, I will make myself available, should it be directed or desired, to address these issues at my level, with my Provincial counterparts: DM for Health, DM for Long-Term Care, or with the Deputy Solicitor General for Ontario (Dep SOLGEN) who is responsible for RFA within the Province.

5. Far more importantly for the health of the residents who are the focus of all concerned, is our transparency and collaborative work with each LTCF to improve the situation so as to have an immediate effect on both daily operations and incremental facility recovery. To that end, I can assure that each ACC team has addressed their own observations with the LTCF management and the competent medical authority available at each site. Every engagement to date has been positive with an acknowledgement by the LTCF that they need to improve, with the improvement on these observed issues being as equal in importance to: overall recovery as proper staffing, sufficient medical resources and supplies, coherent management return on site and establish a working connection to respective health networks.

6. I believe care and attention by our ACC personnel remains our strongest tool in this domain. Notwithstanding the observed deviations in care and accepted practices, our CAF medical professionals lead by example in these LTCF and are ably supported by their non-medical general duty personnel and the structure of the Task Force that enables each ACC team. The content of the annexes was the result of the ACC Nursing Officer team leads, the work of the ACC Senior Nursing Officer, Capt K. Martin and the Regional Surgeon, LCol C. Mercer. Any specific interest with the Annex content is best directed via the Regional Surgeon as JTFC technical authority for the medical content.

7. Sir, I remain available at your convenience for direction or discussion.

Respectfully,

C.J.J. Mialkowski
Brigadier General
Commander

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Annexes

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Annex A to Observation Report on LTCF
Eatonville Care Centre
3350-Op LASER 20-01
14 May 20

EATONVILLE CARE CENTRE
420 THE EAST MALL, ETOBICOKE, ON M9B 3Z9

1. Infection control:
   a. Isolation: COVID-19 positive residents allowed to wander. This means anyone in the facility (staff, residents, and visitors) is at risk of being exposed and passing it throughout the home; as the resident's location is not predictable, full appropriate PPE is not possible;
   b. PPE practices – resident rooms: facility staff are under the impression that if the infection between 2 residents is the same, there's no need to change their gown; and
   c. PPE practices – outside rooms: facility staff often wear PPE outside of rooms and at the nurses station.

2. Standards of practice/quality of care concerns:
   a. Reusing hypodermoclysis supplies even after sterility has been obviously compromised (e.g. catheter pulled out and on the floor for an undetermined amount of time);
   b. Poor palliative care standards – inadequate dosing intervals for some medications, some options limited based on level of staff administering medication (ex: hydromorphone injection won't be given if RN unavailable);
   c. There are no mouth or eye care orders or supplies for palliative residents;
   d. Poor Foley catheter care. CAF SNO (Senior Nursing Officer) reports poor adherence to orders, no consistent safety checks. Significant incidents of excessive sediment or abnormal discharge and bleeding with no follow on action; and
   e. Generally very poor peri-catheterization care reported. Example: Retracting penis foreskin to clean isn't happening on a widespread level. CAF have found nearly a dozen incidents of bleeding fungal infections.

3. Supplies:
   a. General culture of fear to use supplies because they cost money (fluid bags, dressings, gowns, gloves etc);
   b. Key supplies are often under lock and key, not accessible by those who need them for work (e.g. wipes for PSWs); and
   c. Expired medication. Much of the ward stock was months out of date (inference: residents have likely been getting expired medication for quite some time).

4. Ambiguity on local practices:
   a. Extra soaker pad: residents who routinely soil their bed despite incontinence products are not permitted to have an extra soaker pad or towel in bed to help protect sheets and blankets from soiling. (PSWs are afraid for their jobs on this issue) rationalization used is that an extra pad is undignified;
   b. Cohorting residents. Ministry requirement cited as reason they still have negative residents rooming with positive residents; and
   c. Unable to post information that would greatly increase patient safety and appropriate care. Example: an inconspicuous card above bed that stated code status, diet texture/fluid consistency, transfer status etc. was deemed to be "undignified". This

presents a safety risk to residents who may get improper care and liability risk to the care providers.

5. Communication:
   a. PSWs can be task focused and do not always report discovered abnormalities to registered staff;
   b. Policies and facility-specific procedures aren't communicated to staff (example: how to sign for a narcotics shipment, what to do in the event of a call bell failure);
   c. Information about residents is difficult to access and hard to communicate (example: a neurologic exam after a fall is hard to interpret when it's unclear what the resident's baseline neurologic status is);
   d. Information on LTCF COVID status (residents and staff) is not available or updated; and
   e. Management is unable to effectively enforce restrictions on use of CAF PPE.

6. Staffing:
   a. New staff that have been brought to LTCF haven't been trained or oriented;
   b. LTFC is severely understaffed during day due to resident comorbidities and needs (need more PSWs, RPN and RNs);
   c. MDs not present and have to be accessed by phone (not always within reach);
   d. Morale and well-being of staff at risk. Many are overworked, seem burned out and have no time off (some have not seen their families for weeks);
   e. The staffing is such that it is impossible to provide care at a pace that is appropriate to each resident or allow them any kind of independence. (example: a resident states he would like to ambulate to the toilet, a PSWs says, "no I just changed him." Or people are often sedated with narcotics when they are likely just sad or depressed in a context where there isn't the staffing to support the level of care and companionship they need;
   f. ACC staff report not having witnessed any psychosocial support for these residents who have all of a sudden had their families taken away (Reported as "It's heartbreaking to get a report about someone who is "agitated and difficult" and has been getting PRN narcotics or benzodiazepines to sedate them but when you talk to them they just say they're "scared and feel alone like they're in jail" – no agitation or sedation required; and
   g. Gross in-adherence to some recurring orders (example: regular vital signs or patient turning); in some cases PSWs are reported to asking ACC team members not to do these since they "wake up the resident".

7. Inappropriate Behaviour:
   a. CAF member have witnessed aggressive behaviour which ACC staff assessed as abusive/inappropriate. Incidents have been reported to management on numerous occasions. Witness reports have been completed and LTC has commenced investigation to the knowledge of ACC staff. Examples include aggressiveness when changing incontinence product, not stopping or slowing when resident complained of pain, pulling residents, aggressive transfers impacting resident ability to participate in care as able (roll self in bed), degrading or inappropriate comments directed at residents etc;

b. Reports of inaccurate charting or documentation being amended by agency staff following submission regarding patient's pain levels, nutrition, eating status etc; and

c. ACC staff report inaccurate reporting regarding resident's status to family (feeding, pain levels, general condition etc).

8. ACC engagement with facility staff:

a. Concerns were initially raised by the on-site SNO to local leadership. On 4 May 20, a teleconf was conducted between CO TBG1, OC ACC, and leadership from Eatonville Care Centre, as well as corporate management. Major concerns were raised, in particular standards of care issues, poor IPAC, poor charting, narcotic misuse, and wound care. Concerns were raised in a collegial manner and facility staff advised they will address the deficiencies.

Annex B to Observation Report on LTCF
Hawthorne Place Care Centre
3350-Op LASER 20-01
14 May 20

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVE WEST, NORTH YORK, ON M3N 1M9

1. Infection control:
   a. Numerous fans blowing in hallways (increased spread of COVID-19);
   b. Poor training and adherence to IPAC protocols noted;
   c. Significant deterioration of cleanliness standards throughout LTC;
   d. Adherence to IPAC BPG is severely impacted. All ACC and GD pers report numerous incidents of PPE breakdown by LTC staff. Protocols in place have a near 100% contamination rate for equipment, patients and overall facility. Nurses/PSWs are often observed not changing PPE for several hours while moving between numerous patient rooms. Equipment is seldom/ever observed to be disinfected but is used between +ve/-ve patients. Med cart, BP cuffs, thermometers etc. not disinfected between uses;
   e. Little to no disinfection had been conducted at the facilities prior to CAF operations. Significant gross fecal contamination was noted in numerous patient rooms;
   f. Insect infestation noted within LTC - ants and cockroaches plus unknown observed;
   g. Delayed changing soiled residents leading to skin breakdown; and
   h. N95s provided to staff without fit-test.

2. Standards of Practice/Quality of Care Concerns:
   a. Forceful and aggressive transfers, little/no regular turning of patients leading to increased number and complexity of pressure ulcers;
   b. Forceful feeding observed by staff causing audible choking/aspiration, forceful hydration causing audible choking/aspiration;
   c. Patients observed crying for help with staff not responding for (30 min to over 2 hours);
   d. Narcotics are not considered a high alert medication therefore this is no mandatory independent verification required within the LTC. High risk of dosing error;
   e. Activities of Daily Living – staff report residents having not been bathed for several weeks (noted at commencement of task);
   f. DNR status not posted causing staff to race to EMR during code to determine DNR status. CPR has been initiated in absence of ability to verify DNR status (likely futile, and also putting staff at risk as CPR is aerosol generating);
   g. Feeding status not posted/readily available. Given the lack of permanent staff or oversight, patient meals are often mixed up, with incidents of inappropriate meals being fed to residents with swallowing difficulties (increases likelihood of choking or aspiration);
   i. Access to PCC (electronic health record) inconsistent and numerous reports of a lack of charting/documentation by staff causing significant gaps in information;
   j. Reports by SNO of little to no documentation on resident's status within EMR for up to 6 months. Unclear regarding reasons for lack of charting but resident's status indicated a requirement for additional information and documentation;

k. Regular wellness checks suboptimal or inconsistent with staff resulting in many hours between wellness checks day/night shift;
l. SNO reported incident of patient's enteral feed bottle not being changed for so long the contents had become foul and coagulated; date and expiration of contents not noted on bottle;
m. SNO reported incident of permanent catheter being in situ 3 weeks beyond scheduled change date. Catheter was changed by SNO but stated documentation and adherence to timelines was problematic;
n. Topical prescription medicine shared between residents; and
o. Staff report significant lack of appropriate wound care to advanced (stage 4/unstageable) wounds due to significant shortage of supplies, lack of documentation, non-sterile technique, no packing or improper packing of wounds.

3. Supplies:
   a. Wound care supplies insufficient or locked away – high turnover of staff and lack of familiarity with LTC led to poor practices due to supply shortage;
   b. No crash cart available for use in the event of a cardiac arrest;
   c. Linen shortage noted. Either more linens need to be purchased or laundry staff required for night shift. Shortage led to residents sleeping on beds with no linen leading to increased skin breakdown; and
   d. Availability of iPads and time constraints led to significant lack of documentation within EMR. Significant gaps in information exist especially WRT pressure ulcer progression, swallowing status or patient mental status.

4. Ambiguity on local practices:
   a. Palliative care orders not charted/unknown to agency staff thus often not observed;
   b. Resident census and documentation outdated; and
   c. Resident assignment is not clear for PSWs leading to residents being uncared for.

5. Communication:

   a. Poor communication between shifts or lack of handover at shift change led to resident care aspects being missed.

6. Staffing:
   a. No (civilian) RN in the building other than SNO during weekends. SNO and Executive Director (also an RN) only RNs on site on numerous occasions during the week. Significant resultant safety concerns regarding patient ratios (1 RN for up to 200 patients);
   b. Little or no orientation for new staff resulting in low adherence to protocols or a significant awareness of policy;
   c. Contact information and on call schedule not provided to unit staff creates significant delays for referral and direction during emergencies;
   d. Nursing and PSW shift schedule poorly managed. Break time is not planned. Staff disappear and leave the floor unattended;

e. SNO reports that agency pulled back/rerouted RNs when they found out CAF members present resulting in regular degradation of patient ratios and instability of planning;

f. No shift handovers witnessed since arriving on site;

g. PSW often rushed and leave food on table but patients often cannot reach or cannot feed themselves (therefore they miss meals or do not receive meal for hours);

h. Public inter-professional disputes amongst agency/permanent staff; and

i. ACC personnel are heavily relied upon to train and mentor new staff;

7. ACC engagement with facility staff:

a. Concerns were initially addressed by the on-site SNO to local leadership, including charge nurses. On 4 May 20, a teleconf was conducted between CO TBG1, OC ACC, and leadership from Hawthorne Place, as well as corporate management. Major concerns were raised, in particular standards of care issues, poor IPAC, poor charting, and narcotics misuse. Concerns were raised in a collegial manner and facility staff advised they will address the deficiencies, however, given lack of resources available, they may have difficulty in affecting a plan.

ORCHARD VILLA
1955 VALLEY FARM RD, PICKERING, ON L1V 3R6

1. Infection control:
   a. Lack of cleanliness noted:
      1) Cockroaches and flies present; and
      2) Rotten food smell noted from the hallway outside a patient's room. CAF member found multiple old food trays stacked inside a bedside table.
   b. Inappropriate PPE use noted throughout all staffing levels (doctors included); and
   c. Poor IPAC/PPE practices (double/triple gowning and masking, surgical mask under N95, scarves under masks, etc).

2. Standards of Practice/Quality of Care Concerns:
   a. Patient's being left in beds soiled in diapers, rather than being ambulated to toilets;
   b. Mouth care and hydration schedule not being adhered to;
   c. Lack of proper positioning (head of the bed raised) for meals/fluids;
   d. PSW and Nurses aren't always sitting up residents before feeding/hydrating/giving meds; choking/aspiration risk is therefore high; includes observation of incident that appeared to have contributed in patient death (code blue due choking during feeding while supine – staff unable to dislodge food or revive resident);
   e. Respecting dignity of patients not always a priority. Caregiver burnout noted among staff;
   f. Unsafe nursing medication administration errors;
   g. Staff putting food and important belongings outside of residents reach;
   h. Nurses appear to document assessments without actually having assessed the resident;
   i. Incident of likely fractured hip not addressed by staff; Med Tech and SNO addressed and transferred resident to hospital;
   j. Multiple falls, without required assessments following the fall;
   k. Inconsistent and suboptimal assessment and treatment of pain; and
   l. Lack of knowledge evident regarding what qualifies as a restraint. Multiple scenarios of walking aids being removed, or mattresses set on floor as patients were unable to stand from that low position (to prevent them from wandering the facility).

3. Supplies:
   a. Liquid oxygen generators not filled therefore not usable;
   b. Limited and inaccessible wound care supplies;
   c. Found 1 working suction locked in basement storage room; remainder of suction units not functional, last battery check was in 2014;
   d. Oxygen concentrators not easily accessible.
   e. Patients were sleeping on bare mattresses because of lack of access to laundry/linens; and
   f. Poor access to linens, soaker pads, etc.

4. Ambiguity on local practices:
   a. Unable to access LTFC policies easily; cannot access facility's policies without having a login;
   b. Incident reporting channels are "locked", staff unable to report anything other than med errors;
   c. No accessible incident reporting policy in place;
   d. Poor identification of Code status in documentation;
   e. Swallowing assessments not up to date (safety issue);
   f. Minimal familiarity on process to document new orders – orders missed; and
   g. Challenges in contacting on call medical staff leading to confusion and concerns when an emergency in progress.

5. Communication:
   a. Communication inconsistencies between expectations from LTCF leadership and the floor staff regarding facility's policies;
   b. No communication between PSWs and RPN/RNs that patients are choking with meals, or unable to chew/swallow etc.; and
   c. Poor communication between facility management and housekeeping. Patients being moved into rooms that have not been cleaned due to miscommunications.

6. Staffing:
   a. Lack of training for new/agency staff. Nursing staff unsure where or how to document status changes, how to change medications, where order sets are located, where supplies are located etc; lack of knowledge IRT suction equipment, code procedures;
   b. No accountability for staff in regards to upholding basic care needs or best practices;
   c. Poor or no handover between shifts; lack of teamwork or collaboration, blame previous shift for poor care; and
   d. Initially some registered staff did not have access to electronic charting system.

7. ACC engagement with facility staff:
   a. Concerns were initially raised by on-site SNOs to facility leadership, such as charge nurses. On 11 May 20, a teleconf was conducted between CO TBG1, OC ACC. and leadership from Orchard Villa. Concerns were raised regarding these issues, particularly staffing levels, internal communications, standards of practice, and poor IPAC. Concerns were raised in a collegial manner and facility staff advised they will address the deficiencies.

ALTAMONT CARE COMMUNITY
92 ISLAND RD. SCARBOROUGH. ON M1C 2P5

1. Standards of Practice/Quality of Care Concerns:
   a. Inadequate nutrition – due to significant staffing issues, most residents were reported to not having received 3 meals per day and there was significant delay in meals. Poor nutritional status due to underfeeding was reported by ACC personnel;
   b. Significant number of residents have pressure ulcers, stage 2, 3 and 4 and unstageable as a result of prolonged bed rest. ACC have identified 15 residents having wounds that require significant care plan; Wound dressing orders have not been updated nor adhered to by agency staff causing further degradation of wound; wound care nurse scheduled to visit LTC every Wednesday to do dressing changes, however she was not able to come in the 2 weeks preceding this report, resulting in a significant deterioration of the wound care management and dressing changes;
   c. At time of arrival many of the residents had been bed bound for several weeks; No evidence of residents being moved to wheelchair for parts of day, repositioned in bed, or washed properly;
   d. A non-verbal resident wrote disturbing letter alleging neglect and abuse by a PSW. Letter was handed to Med Tech by resident and was immediately brought to the attention of management. Note: this was handled immediately by the LTFC management team; and
   e. SNO reported significant concerns regarding agency staff clinical skills. Some of the personnel such as RPNs require clinical updates in order to continue practicing safely. The following are reported examples:
      1) A resident's blood sugar was assessed as 5.7mmol/L, the RPN was about to give Humalog, when SNO realized it, it was identified to the RPN that Humalog is a rapid acting insulin thus an inappropriate medication. The RPN states it is a long action and that there is no problem to administer it. After SNO insist on confirmation of protocol, it is identified that the Humalog protocol indicate to not administer if Blood sugar is lower than 10mmol/L;
      2) RPN states she is not able to dilute and administer Ceftriaxone IM. SNO had to show to RPN how to reconstitute and administer the medication;
      3) The RPN are using the wrong bandages and non-sterile dressings for packing. Wound care and packing were inappropriately completed by RPN requiring SNO to redo the packing;
      4) Resident was complaining of chest pain. RPN and SNO conducted assessment of resident and advised on call physician. Physician ordered Nitroglycerin. Patient's BP was 95/62 thus contraindication was communicated to physician who insisted on the treatment using Nitroglycerin. SNO and RPN withheld drug related to safety reasons; and
      5) When initiating and installing a subcutaneous butterfly, nurses are priming the line with NS and not the proper medication – not best practice.

2. Supplies:
   a. The facility has insufficient wound care material and supplies; and
   b. Residents have no way to receive additional personal supplies since the lockdown. They are unable to receive personalized shampoo, snacks, magazines, newspapers etc.

3. Ambiguity on local practices:
   a. LTCF had no accurate nominal roll as to resident room and bed locations. This came to ACC attention during an emergency when our facility experienced a flooding issue in one of the wards; and
   b. ACC staff reported that medications are being reported/documented as being given but in fact they are not. Some agency staff have only been providing regular PO meds and not giving elixirs, drops nor PRN medication.

4. Staffing:
   a. Scheduling is a significant concern at this facility:
      1) Evening shift is unstable, often no PSWs are present after 1430. PSW ratio often 1 per wing (30-40+ patients/PSW);
      2) The current staff to patient ratio at the facility do not allow for more care than the most basic daily requirements. Residents are changed and fed, however no ability to provide nail care, skin care, repositioning, nor adequate wound care;
      3) Night shift also understaffed and often requires significant movement of personnel within facility to stabilize number of personnel between wings; and
      4) Unverified reports of only 2 x PSW within facility during ACC rest day.
   b. Staff members (especially the nurses) avoid shrouding/post-mortem care of the deceased patients; very few PSW's assist with the post-mortem care and often times (when CAF present) they leave the military staff to do the post-mortem care;
   c. Regular arguments between staff observed (with derogatory language);
   d. There is no administrator present for evening/night shifts and no systems are being utilized to ensure follow up on incident reports;
   e. ACC on wing 4 have identified that since the regular staff have returned, they are rushing patients, not respecting their pace and have been observed making degrading or inappropriate comments directed at residents; and
   f. Kitchen staff do not attend to the snack cart during night shift and nursing staff are forbidden from entering the kitchen. Residents often get hungry around 3-4AM and are told they can have a cookie, some cold coffee, or wait until morning. ACC staff have been supplementing where necessary with personal food supplies to ensure that residents don't go hungry.

5. ACC engagement with facility staff:
   a. Concerns were initially raised by on-site SNOs to facility leadership, such as charge nurses. On 8 May 20, a teleconf was conducted between CO TBG1, OC

ACC, and leadership from Altamont. Concerns were raised regarding these issues, particularly standards of practice issues and poor IPAC. Concerns were raised in a collegial manner and facility staff advised they will address the deficiencies. In fact, staff advised that infection curve was flattening and that staffing levels were increasing.

Annex E to Observation Report on LTCF
Holland Christian Homes (Grace Manor)
3350-Op LASER 20-01
14 May 20

HOLLAND CHRISTIAN HOMES (GRACE MANOR)
7900 MCLAUGHLIN RD, BRAMPTON, ON L6Y 5A7

1. Infection control:
   a. Staff moving from COVID+ unit to other units without changing contaminated PPE;
   b. Some staff not following IPAC policies (i.e. not hand washing between patient interactions);
   c. Wearing same pair of gloves for several tasks from one patient to another;
   d. Cleaning gloves between patients with hand sanitizer; and
   e. No staff break room on COVID+ floor where PPE can be removed in order to eat.

2. Standards of Practice/Quality of Care Concerns:
   a. Improper sterile technique with dressing changes (i.e. wound packing);
   b. PRN medication administration not always documented;
   c. Improper documentation regarding patient DNR status; and
   d. Concerns about agency staff:
      1. Leaving food in a resident's mouth while they are sleeping;
      2. Aggressively repositioning a resident;
      3. Improper use of lifts; and
      4. Not assisting residents during meals (staff would rather write the resident refused to eat, rather than helping them.

4. ACC engagement with facility staff:
   a. On 7 May 20, a teleconf was conducted between CO TBG1, OC ACC, and leadership from Holland Christian Homes. Minor concerns were raised in a collegial manner and facility staff advised they will address the deficiencies.