Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: February 2, 2024
Inspection Number: 2024-1343-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Hamilton, Hamilton

Lead Inspector	**Inspector Digital Signature**
Lisa Vink (168)	Lisa Vink Digitally signed by Lisa Vink Date: 2024.02.02 15:56:19 -05'00'

Additional Inspector(s) Lesley Edwards (506)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 23, 24, 25, 26, 29, 30, 31, 2024.

The following intake was inspected:

- Intake: #00106459 - Proactive Compliance Inspection for Extendicare Hamilton.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration

Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident's written plan of care identified they required an intervention. The resident stated they did not and had not used the intervention while in the home.

The Kardex nor the progress noted included information related to the intervention.

Staff acknowledged they were unaware of the intervention in the resident's plan of care since they worked with the resident.

The written plan of care was amended by staff following a review of the resident's status, to be consistent and provide clear direction to staff.

Sources: Clinical record of the resident; interview with the resident and staff. [506]

Date Remedy Implemented: January 31, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for two residents set out clear directions to staff and others who provided direct care to the residents.

Rationale and Summary
The care plan binder included hard copies of plans for two residents related to their nutritional needs. The plan of care for one resident was printed in July 2023, and included a specified diet and the plan of care for the second resident was printed in September 2023, and noted a specified nutritional risk level.

Electronic plans of care, reviewed the following day included that the first resident

was on a different textured diet, since January 2024, and the second resident was at a different level of nutritional risk, since January 2024.

The hard copy plans of care and electronic plans did not provide clear directions to staff as the documents were not consistent with each other, as acknowledged by staff.

Subsequently, the care plan binder included hard copies of the plans of care with a print date of January 26, 2024.

Sources: Observations of the noon meal, review of the clinical health records for the residents including plans of care and assessments; and interviews with staff. [168]

Date Remedy Implemented: January 26, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
The home's policy to promote zero tolerance of abuse and neglect was not posted in the home. Staff acknowledged the policy was not posted and it was posted the same day on the main information board.

Sources: Observation and interview with staff. [506]

Date Remedy Implemented: January 23, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (d)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(d) an explanation of the duty under section 28 to make mandatory reports.

The licensee has failed to ensure that an explanation of the duty under section 28 to make mandatory reports was posted in the home.

Rationale and Summary
The explanation of the duty under section 28 to make mandatory reports was not posted in the home. Staff acknowledged the document was not posted and it was posted the same day on the main information board.

Sources: Observation and interview with staff. [506]

Date Remedy Implemented: January 23, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (g)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained.

The licensee has failed to ensure that the notification of the home's policy to minimize the restraining of residents was posted in the home.

Rationale and Summary
The home's policy to minimize the restraining of residents was not posted in the home. Staff acknowledged the policy was not posted and it was posted the same day on the main information board.

Sources: Observation and interview with staff. [506]

Date Remedy Implemented: January 23, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30.

The licensee has failed to ensure that an explanation of the protections afforded under section 30, whistle-blowing protections was posted in the home.

Rationale and Summary
The explanation of the protections afforded under section 30, whistle-blowing protections was not posted in the home. Staff acknowledged the explanation was not posted and it was posted the same day on the main information board.

Sources: Observation and interview with staff. [506]

Date Remedy Implemented: January 23, 2024

NC #007 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard, revised September 2023, issued by the Director was complied with. Specifically, the licensee failed to ensure IPAC Standard Section 9.1 (e) related to additional precautions was complied with for at a minimum of point of care signage which indicated the enhanced IPAC control measures required.

Rationale and Summary
A resident's bedroom door had personal protective equipment in place; however, there was no signage, which identified that precautions were required. Staff put signage in place once the concern was identified.

Sources: Observation of a resident's room and interview staff. [506]

Date Remedy Implemented: January 23, 2024

NC #008 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-

term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the home's current version of their visitor policy was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the FLTCA, the licensee was to ensure that the visitor policy was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements established by the regulations.

The home's visitor policy was not posted. Staff acknowledged the policy was not posted and it was posted the same day on the main information board.

Sources: Observation and interview with staff. [506]

Date Remedy Implemented: January 23, 2024

WRITTEN NOTIFICATION: Plan of care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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.

The licensee has failed to ensure that there was a written plan of care for a resident

that set out the planned care for the resident.

Rationale and Summary
A resident was assessed by the Registered Dietitian who noted the use of aids when drinking.

The meal service notes available for dietary staff at the point of service identified different aids when drinking, which was consistent with the electronic care plan.

The planned care for the resident was included in the progress notes; however, was not set out in the written care plan which all staff were able to access.

Sources: Review of the plan of care, meal service notes and nutritional assessment for a resident, observations of noon meal, and interview with staff. [168]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to seek the advice of the Residents' Council and the Family Council in carrying out the survey.

Rationale and Summary
The annual Resident and Family/Caregiver Experience Survey was conducted in the home in the fall of 2023.

The advice of neither the Residents' Council nor Family Council was sought in how to conduct the survey, as confirmed by staff.

Sources: A review of Residents' and Family Council Meeting Minutes for 2023; and interviews. [168]

WRITTEN NOTIFICATION: Powers of Residents' Council

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (1) 9. i.
Powers of Residents' Council
s. 63 (1) A Residents' Council of a long-term care home has the power to do any or all of the following:
9. Review,
i. inspection reports and summaries received under section 152.

The licensee has failed to ensure that the Residents' Council was provided with inspection reports and summaries to review as received under section 152 of FLTCA.

Rationale and Summary
The 2023 Residents' Council Meeting Minutes did not include copies of Ministry of Long-Term Care Inspection Reports for inspections conducted in 2023, as confirmed by staff.

Sources: Review of Residents' Council Meeting Minutes and interview with staff. [168]

WRITTEN NOTIFICATION: Powers of Residents' Council

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 63 (3)

Powers of Residents' Council

s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that when the Residents' Council advised them of concerns or recommendations under either paragraph 6 or 8 of subsection (1), they within 10 days of receipt the advice, responded to the Residents' Council in writing.

Rationale and Summary

Residents' Council Meeting Minutes from 2023, identified examples where concerns or recommendations were made by the council to the licensee and specific written responses were not provided to the council within 10 days.

Staff verbalized there were occasions where responses were provided at the meeting: however, not recorded in the minutes, or generalized written responses were provided within 10 days, not specific to the issue or concern raised.

Failure to respond in writing to Residents' Council concerns or recommendations had the potential for issues to not be addressed or a misunderstanding of responses provided.

Sources: Review of Residents' Council Meeting Minutes and interviews. [168]

WRITTEN NOTIFICATION: Powers of Family Council

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 66 (1) 7. i.

Powers of Family Council

s. 66 (1) A Family Council of a long-term care home has the power to do any or all of the following:

7. Review,

i. inspection reports and summaries received under section 152.

The licensee has failed to ensure that the Family Council was provided with inspection reports and summaries to review as received under section 152 of FLTCA.

Rationale and Summary

The 2023 Family Council Meeting Minutes did not include copies of Ministry of Long-Term Care Inspection Reports for inspections conducted in 2023, as confirmed by staff.

Sources: Review of Family Council Meeting Minutes and an interview with staff. [168]

WRITTEN NOTIFICATION: Powers of Family Council

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 66 (3)

Powers of Family Council

s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee has failed to ensure that when the Family Council advised them of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee within 10 days of receipt the advice, responded to the Family Council in writing.

Rationale and Summary
Family Council Meeting Minutes identified a concern which was made by the council in 2023, to the licensee and a response was not provided to the council, in writing, within 10 days, as confirmed by staff.

Sources: Review of Family Council Meeting Minutes and interviews with staff. [168]

WRITTEN NOTIFICATION: Training

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that the persons who received training under subsection (2) received the retraining in the areas mentioned in that section at the intervals as provided for in the regulations.

Rationale and Summary
FLTCA s. 82 (1) identified that all staff in the home were to receive training in the areas as required.

FLTCA s. 82 (2) identified that training was required in the areas, including: the home's policy to promote zero tolerance of abuse and neglect and the duty under section 28 to make mandatory reports.
O. Reg. 246/22 s. 260 (1) identified the retraining was to be completed at annual intervals.

Course completion records for staff training on Zero Tolerance of Resident Abuse and Neglect identified that in 2023, only 94.9 per cent of the staff completed the required training.

There was a risk that not all staff were familiar with the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to make mandatory reports, when they did not receive annual retraining as required.

Sources: Training records and interview with staff. [506]

WRITTEN NOTIFICATION: General requirements

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under the nutritional care and hydration program, included the interventions and the resident's response documented.

Rationale and Summary
A resident was provided with tray room service for the noon meal. Point of Care (POC) records, for the task meals and fluids - percentage consumed, was not completed as there was no documentation for the meal, specifically what was consumed.

Failure to document the resident's response to the noon meal resulted in incomplete records for future assessment data, if necessary.

Sources: Review of POC records and progress notes for a resident and interviews with staff. [168]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted a resident.

Rationale and Summary
A resident was observed to be transferred to into a shower chair, by two PSW's, in their room. The resident was then portered in the chair, independently by a staff member, down the corridor and to the spa room. The chair was not in the lowest position nor was the safety belt secured around the resident during the transfer. The home's policy Safe Lifting for Care Program, stated that two staff members

were required at all times, that residents would be transferred over the shortest distance, under no circumstances would they be transported with a mechanical lift (across a room or down a hallway) and that the safety belt was to be placed on the resident at all times.

Failure to ensure that staff used safe transferring and positioning techniques when they assisted a resident increased their risks for injury and harm.

Sources: Observations of a resident; interviews with staff and review of the Safe Lifting for Care Program policy. [506]

WRITTEN NOTIFICATION: Hazardous substances

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Rationale and Summary
In accordance with O. Reg. 246/22, s. 12 (1) 3, all doors which lead to non-residential areas were to be equipped with locks which restricted unsupervised access to those areas by residents, and those doors kept closed and locked when not supervised by staff.

Two utility room doors, which had signage posted to keep the doors locked at all times, were left unlocked. On entry to the rooms, there were containers of Oxivir Tb liquid in the cupboards and on the counter.

Staff acknowledged that the doors were to be locked when staff were not present.

There was a potential risk of chemical exposure to residents when hazardous substances were accessible through unlocked doors.

Sources: Observations and interview with staff. [506]

WRITTEN NOTIFICATION: Annual evaluation

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (3) (a)
Annual evaluation
s. 125 (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 124

The licensee has failed to ensure that the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year as referred to in section 124 of the regulations.

Rationale and Summary
The 2023 Annual Medication Evaluation did not include a review of the previous quarterly evaluations of the previous year as confirmed by staff.

Sources: Review of the 2023 Annual Medication Evaluation tool and interview with

staff. [168]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The licensee has failed to ensure that a medication incident which involved a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
A Medication Incident Report (MIR) identified that a resident was involved in a medication incident, when staff failed to administer a specified medication.

The electronic Medication Administration Record (eMAR) identified the resident was not prescribed the identified medication, but rather a different medication. Staff confirmed that an incident occurred; however, the MIR was incorrect for the medication involved, and the actual incident was not documented.

Failure to ensure that medication incidents were documented had the potential for follow up actions to be inconsistent with the needs of the resident.

Sources: A review of MIR, progress notes, and eMAR for a resident and interview with staff. [168]

WRITTEN NOTIFICATION: Medication incident and adverse drug reactions

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (b)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(b) corrective action is taken as necessary.

The licensee has failed to ensure that medication incidents involving two residents had corrective action taken as necessary.

Rationale and Summary
Medication Incident Reports (MIRs) identified that two residents were involved in medication incidents, when medications were not administered as prescribed. The MIRs for both incidents did not include that corrective action was taken related to the incidents.

Staff confirmed the expectation that corrective action be taken for all medication incidents; however, that actions were not taken related to these incidents of medication omission.

Failure to take corrective action for medication incidents had the potential that staff were unaware of any root causes of the incidents and that undesired practices continued.

Sources: Review of MIRs for two residents and interview with staff. [168]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (c)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee has failed to ensure that medication incidents which involved two residents had a written record kept of the review and analysis of the incidents.

Rationale and Summary
MIRs identified that medication incidents occurred which impacted two residents. A review of the reports did not include a written record of a review or analysis of the incidents as confirmed by staff.

Sources: Review of MIRs for residents and interview with staff. [168]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.

Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
4. Every designated lead of the home.

The licensee has failed to ensure that the continuous quality improvement committee included every designated lead of the home.

Rationale and Summary
Staff confirmed that not every designated lead of the home was part of their continuous quality improvement committee.

Sources: Review of Terms of Reference, meeting minutes and interview with staff. [168]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee has failed to ensure that the continuous quality improvement committee included a member of the regular nursing staff of the home.

Rationale and Summary
Staff confirmed the continuous quality improvement committee did not include a member of the home's regular nursing staff.

Sources: Review of Terms of Reference, meeting minutes and interview with staff. [168]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the continuous quality improvement committee included a personal support worker, as required.

Rationale and Summary
Staff confirmed the continuous quality improvement committee did not include a personal support worker, as required.

Sources: Review of Terms of Reference, meeting minutes and interviews with staff. [168]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

The licensee has failed to ensure that the continuous quality improvement committee included a member of the Residents' Council.

Rationale and Summary
Staff confirmed that the continuous quality improvement committee did not include a representative of the Residents' Council.

Sources: Review of Terms of Reference, meeting minutes and interviews with staff. [168]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

10. One member of the home's Family Council, if any.

The licensee has failed to ensure that the continuous quality improvement committee included a member of the Family Council.

Rationale and Summary
Staff confirmed that the continuous quality improvement committee did not include a representative of the Family Council.

Sources: Review of Terms of Reference, meeting minutes and interviews with staff. [168]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the continuous quality improvement initiative report was provided to the Residents' Council and Family Council.

Rationale and Summary
The 2023 Residents' and Family Council Meeting Minutes did not include that the councils were provided a copy of the home's continuous quality improvement initiative report, as confirmed by staff.

Sources: Review of the Residents' and Family Council Meeting Minutes and interviews. [168]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee has failed to ensure that all staff who provided direct care to residents completed training on skin and wound care in 2023.

Rationale and Summary
Training records for direct care staff on skin and wound care identified a completion rate for 2023, at approximately 91 per cent.

There was risk that some care staff were not familiar with the home's skin and wound care program when they did not complete training as required.

Sources: Surge Course Completion report and interview with staff. [168]