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

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Original Public Report

Report Issue Date: September 16, 2024
Inspection Number: 2024-1057-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Norwood Nursing Home Limited
Long Term Care Home and City: Norwood Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 25, 26, 29-31, 2024 and August 1, 2, 6-9, 12, 2024
The inspection occurred offsite on the following date(s): September 9, 10, 2024

The following intake(s) were inspected:

- Intake: #00122148 - Proactive Compliance Inspection

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

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

Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain 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: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that all doors leading to non-residential areas were kept locked when not supervised by staff.

Rationale and Summary
A laundry room door was observed to be unlocked.

A laundry staff stated that the battery for the keypad lock of the laundry room door had been out of service for several days and no key was used to keep the door locked during this time. The Operational Manager confirmed that the battery of the keypad lock on the laundry room door had been replaced by the end of the day.

On the following day, the door of the laundry room was observed to be closed and locked.

Failure to ensure doors leading to non-residential areas were kept locked when not supervised by staff has the potential to place residents' safety at risk.

Sources: Observations; and interviews with laundry staff and the Operational Manager.

[000757]

Date Remedy Implemented: July 26, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of care to a resident was documented.

Rationale and Summary
A resident required care due to the presence of altered skin integrity.

The resident's clinical records indicated no documentation of wound care was provided to them on an identified date. A Registered Nurse (RN) verified that they provided wound care to the resident but had not documented the care.

Both the RN and Assistant Director of Care (ADOC) acknowledged that wound care provided to the resident should have been documented.

Failure to document the provision of wound care to the resident poses a risk of staff not knowing if care was provided.

Sources: Resident's clinical records; and interviews with a RN and ADOC.

[000757]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (a)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (4);

The licensee has failed to ensure that the results of the survey were documented and made available to the Residents' Council and the Family Council.

Rationale and Summary
A review of the home's 2024 Resident Satisfaction Survey Report included documentation of the results and summary of the responses. There was no record of the results of the survey being made available to the Residents' Council and Family Council.

The Activity Director confirmed that the results of the survey were not made available to the Residents' Council and Family Council.

Failure to ensure that the results of the survey were made available to Residents' Council and Family Council could impact the ability to obtain further feedback in quality initiatives.

Sources: Resident Satisfaction Survey Report; and interview with the Activity Director.

[740836]

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (b)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(b) the actions taken to improve the long-term care home, and the care, services,

programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

The licensee has failed to ensure the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey were documented and made available to the Residents' Council and the Family Council.

Rationale and Summary
A review of the home's 2024 Resident Satisfaction Survey Report included documentation of the results and summary of the responses, including areas of improvement and the actions to be taken to enhance the quality of care and services. There was no record of the actions taken based on the results of the survey being made available to the Residents' Council and Family Council.

The Activity Director confirmed that the results of the survey, including actions taken to improve the long-term care home, were not made available to the Residents' Council and Family Council.

Failure to ensure that the results of the survey, including actions taken to improve the long-term care home were made available to Residents' Council and Family Council could impact the ability to obtain further feedback in quality initiatives.

Sources: Resident Satisfaction Survey Report; and interview with the Activity Director.

[740836]

WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (c)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and

The licensee has failed to ensure that the documentation required by clauses (a) and (b) was made available to residents and their families.

Rationale and Summary
A review of the home's 2024 Resident Satisfaction Survey Report included documentation of the results and summary of the responses, including areas of improvement and the actions to be taken to enhance the quality of care and services. There was no documentation record of the results of the survey or actions taken based on the results of the survey being made available to residents and their families.

The Activity Director acknowledged that there was no documentation of the results of the survey, including actions taken to improve the long-term care home, made available to residents and their families.

Failure to ensure that there was documentation of the results of the survey, including actions taken to improve the long-term care home were made available to residents and families could impact the ability to obtain further feedback in quality initiatives.

Sources: Resident Satisfaction Survey Report; and interview with the Activity

Director.

[740836]

WRITTEN NOTIFICATION: Duty to respond

NC #006 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 Resident's Council advised them of concerns or recommendations, the licensee within 10 days of receiving the advice, responded to the Residents' Council in writing.

Rationale and Summary
A review of the home's Residents' Council Meeting Minutes identified concerns during different meetings regarding: staffing, maintenance and repairs, and length of dining time and meal portion sizes. There was no written response provided to Residents' Council regarding the identified concerns.

The Activity Director stated that the home addressed the concerns with the Residents' Council verbally at their next council meeting, but did not provide a written response within 10 days.

Failure to respond to Residents' Council in writing within 10 days could result in concerns or recommendations not being addressed.

Sources: Residents' Council Meeting Minutes; and interview with the Activity Director.

[740836]

WRITTEN NOTIFICATION: Windows

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every windows in the home that opens to the outdoors and were accessible to residents had screens.

Rationale and Summary
During an initial tour of the home, the inspector observed windows in several resident rooms with no screens. The Operational Manager verified that these windows had been missing screens for about one and a half years.

Failure to ensure that windows in residents' rooms have screens poses a safety risk for residents in the home.

Sources: Observation; and interview with the Operational Manager.

[000757]

WRITTEN NOTIFICATION: Air temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
The home's Air Temperature and Monitoring Log documented multiple days and areas where temperature readings ranged from 19 to 21 degrees Celsius between mid May to end of July 2024. These included temperatures documented in a resident room, and nursing stations and television rooms on the first and second floors.

The Food Service and Environmental Manager (FSM) and Operational Manager both acknowledged that there were multiple days in which the home's temperature was not maintained at a minimum of 22 degrees Celsius.

Failure to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius put residents at risk of experiencing discomfort.

Sources: Home's air temperature and monitoring logs; and interviews with the FSM and Operational Manager.

[740836]

WRITTEN NOTIFICATION: Air temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

Rationale and Summary
The inspector requested a copy of the home's air temperature monitoring logs. The temperature in the home was not measured and documented in the following areas on multiple identified dates: at least two resident bedrooms on the first and second floors, one resident common area on every floor of the home, and designated cooling areas in the home.

The FSM and Operational Manager both acknowledged that the temperatures were not measured and documented on numerous dates in May to July 2024 in different areas within the home as staff were not consistent in documenting the temperatures. The FSM also stated that there was risk to residents' health and hydration when temperatures were not monitored and documented.

Failure to measure and document the air temperatures could result in delay in identifying changes to residents' health status.

Sources: Home's Air Temperature Monitoring Logs; and interviews with the FSM and Operational Manager.

[740836]

WRITTEN NOTIFICATION: Air temperature

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature was required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
The inspector requested a copy of the home's air temperature monitoring logs. The

air temperature monitoring logs identified multiple days and times in which temperatures were not consistently monitored and documented, for resident bedrooms, common areas, and designated areas throughout the home. This included: 9 days the temperature was never measured, 69 days the temperature was not measured in the morning, 67 days the temperature was not measured between 12 p.m. and 5 p.m., and 10 days the temperature was not measured in the evening or night.

The FSM and Operational Manager both confirmed that the temperatures were not measured and documented at the identified timeframes in the different areas within the home. The FSM also stated that there was risk to residents' health and hydration when temperatures were not monitored and documented.

Failure to measure and document the air temperatures could result in delay in identifying changes to residents' health status.

Sources: Home's Air Temperature Monitoring Logs; and interviews with the FSM and Operational Manager.

[740836]

WRITTEN NOTIFICATION: General requirements

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section

53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the pain management and skin and wound care programs were evaluated and updated annually.

Rationale and Summary
i) The home's Pain Management Policy indicated no last reviewed date.

The Pain Management Program Lead and ADOC both verified that the home had never conducted annual evaluations of the pain management program.

Failure to evaluate and update the pain management program may potentially lead to missed opportunities to improve the program.

Sources: The home's Pain Management Policy; and interviews with the Pain Management Program Lead and ADOC.

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ii) The inspector requested the annual program evaluation record for the skin and wound care program. The ADOC verified that the home had never conducted annual evaluations of the skin and wound care program.

Failure to evaluate and update the skin and wound care program may potentially lead to missed opportunities to improve the program.

Sources: Interview with the ADOC.

[000757]

WRITTEN NOTIFICATION: Nursing and personal support services

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (d)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work; and

The licensee has failed to ensure there was a written back-up plan for nursing that addressed situations when staff could not come to work.

Rationale and Summary
In review of the home's staffing plan, the Director of Care (DOC) was not able to provide a written back-up plan for nursing that addressed situations when staff could not come to work.

The DOC stated that the home followed a contingency plan for registered nursing staff, however, the plan was not written out.

Failure to have a written back-up plan for nursing staff may potentially impact the home's ability to respond to nursing staff shortages to provide essential resident care.

Sources: The home's back-up plans for nursing and personal support staff; and interview with the DOC.

[000757]

WRITTEN NOTIFICATION: Nursing and personal support services

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (e)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the staffing plan was evaluated and updated annually.

Rationale and Summary
The home's written staffing plan was last reviewed and updated in 2022. The DOC verified that the home had been using the same staffing plan and annual evaluation of the plan had not been conducted since 2022.

Failure to evaluate and update the staffing plan annually may impact the home's ability to assess appropriate staffing levels to meet resident care needs.

Sources: Home's staffing plan; and interview with the DOC.

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WRITTEN NOTIFICATION: Required programs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that a resident's pain assessment was documented in weekly progress notes by registered nursing staff.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a pain management program that provided strategies to manage and monitor pain in residents and must be complied with. Specifically, registered nursing staff did not comply with the home's Pain Management Policy to document pain assessment weekly in Med-e-Care progress notes.

Rationale and Summary
A resident's clinical records indicated that they had pain related to their medical conditions.

The home's Pain Management Policy directs registered nursing staff to document pain assessments for residents in Med-e-Care progress notes weekly. The resident's progress notes revealed that registered nursing staff had not been documenting pain assessments weekly to indicate the resident's pain status.

The ADOC acknowledged that registered nursing staff did not comply with the

home's policy by documenting the resident's pain assessment weekly in Med-e-Care progress notes.

Failure to document weekly pain assessment poses the risk of resident having unrelieved pain and staff not able to determine the effectiveness of the pain management interventions.

Sources: Resident's clinical records; home's Pain Management Policy; and interview with the ADOC.

[000757]

WRITTEN NOTIFICATION: Skin and wound care

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that residents #016 and #017's skin altered skin integrity were reassessed at least weekly.

Rationale and Summary
i) Resident #016's clinical records indicated that they had altered skin integrity.

A RN confirmed that weekly skin assessments were missing for several weeks.

Both the RN and ADOC acknowledged that weekly skin assessments should have completed for the resident until their altered skin integrity had resolved.

There was a risk for delayed implementation of interventions to promote healing for residents when their weekly skin assessments were not completed.

Sources: Resident #016's clinical records; and interviews with a RN and ADOC.

[000757]

ii) Resident #017's clinical records indicated that they had skin altered skin integrity.

A RN confirmed that weekly skin assessments were missing for several weeks.

Both the RN and ADOC acknowledged that weekly skin assessments should have completed for the resident until their altered skin integrity had resolved.

There was a risk for delayed implementation of interventions to promote healing for residents when their weekly skin assessments were not completed.

Sources: Resident #017's clinical records; and interviews with the RN and ADOC.

[000757]

WRITTEN NOTIFICATION: Skin and wound care

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that when a resident exhibited altered skin integrity that was likely to require or respond to nutrition intervention, was assessed by a Registered Dietitian (RD).

Rationale and Summary
A resident had multiple altered skin integrity. The resident's clinical records indicated they were referred to the RD. However, they were not assessed by the RD. A RN and ADOC both stated the resident was at nutritional risk due to their medical conditions and a referral to the RD was clinically indicated due to resident's health history.

The ADOC verified that there had been no assessments completed by the RD for the resident.

Failure to have nutritional assessment and interventions may potentially delay healing.

Sources: Resident's clinical records; and interviews with the RN and ADOC.

[000757]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (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 their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's plan of care was implemented to promote and manage bowel and bladder continence.

Rationale and Summary
A resident's plan of care stated they were incontinent and staff were required to check the resident for incontinence care.

During an observation of a resident, they were not provided continence care and were not checked by staff. A PSW acknowledged that they did not follow the resident's care plan to assist with continence care.

Failure to ensure the resident's plan of care was implemented to promote and manage bladder continence could increase the risk of altered skin integrity.

Sources: Observation; resident's clinical records; and interviews with a PSW and other staff.

[000757]

WRITTEN NOTIFICATION: Menu planning

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that a written record was kept of the evaluation of the menu cycle that included the date of evaluation, the names of the persons who participated in the evaluation, a summary of the changes and the date that the changes were implemented.

Rationale and Summary
The inspector requested a copy of the written record of the current evaluation of the menu cycle that was in place at the time of the inspection. The FSM provided the current food menu cycle, but was unable to provide a copy of the written record of the evaluation of the menu cycle. The FSM stated the current menu cycle was evaluated by the Registered Dietitian and previous FSM prior to the menu cycle being implemented, but was unable to locate the written record.

Failure to ensure that a written record of the menu cycle evaluation was retained could impact the ability to further evaluate residents' nutritional needs and preferences.

Sources: Home's food menu cycle; and interview with the FSM.

[740836]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 4.3 stated that the licensee shall ensure that following the resolution of an outbreak, the outbreak management team and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices. And, s. 9.1 (d) stated that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Additional Precautions shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary

i) The home declared a respiratory outbreak for a period of two weeks.

The IPAC Lead stated that the interdisciplinary IPAC team had not conducted debrief sessions following resolutions of outbreaks to assess IPAC practices and make recommendations to the licensee for improvements to outbreak management practices in the home.

Failure to conduct debrief sessions following the resolutions of outbreaks may impede the home's ability to improve the management of future outbreaks.

Sources: The home's post outbreak debrief session record; and interview with the IPAC Lead.

[000757]

ii) A Personal Support Worker (PSW) was observed wearing a surgical mask arriving in front of a resident's room who was on droplet and contact precautions. Prior to entering the resident's room, the PSW performed hand hygiene and donned a gown. No gloves and face shield were donned prior to entering the resident's room. The PSW interacted with the resident in close proximity then removed their gown and performed hand hygiene prior to exiting the resident room.

The PSW acknowledged that they should have worn the face shield and gloves prior to entering the resident's room.

Failure to apply the appropriate PPEs increases the risk of infection transmission.

Sources: Observation; and interviews with the PSW and other staff.

[000757]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (1)
Continuous quality improvement committee
s. 166 (1) Every licensee of a long-term care home shall establish a continuous quality improvement committee.

The licensee has failed to establish a continuous quality improvement (CQI) committee.

Rationale and Summary
The inspector requested a copy of the home's CQI committee agenda and minutes. The ADOC was unable to provide the documents as there was no CQI committee at the home. The ADOC acknowledged that the home did not have a formal CQI committee in place.

Failure to establish a CQI committee may result in any recommendations not being identified.

Sources: Interview with the ADOC.

[740836]

WRITTEN NOTIFICATION: Continuous quality improvement designated lead

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 167 (1)
Continuous quality improvement designated lead
s. 167 (1) Every licensee of a long-term care home shall ensure that the home's continuous quality improvement initiative is co-ordinated by a designated lead.

The licensee has failed to ensure that the home's continuous quality improvement initiative (CQI) is co-ordinated by a designated lead.

Rationale and Summary
The home's current CQI initiative report did not include the name of the designated lead, as there was no lead in place.

The Director of Care (DOC)/Administrator acknowledged that the home's CQI initiative did not have a designated lead formally, as there was no CQI committee in place.

Failure to ensure that the home's CQI initiative was co-ordinated by a designated lead may result in a lack of coordination when developing quality improvement initiatives.

Sources: CQI Initiative Report; and interview with the DOC/Administrator.

[740836]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the home's Continuous Quality Improvement (CQI) initiative report contained a written record of,

i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary

The home's CQI initiative report for the 2023/2024 fiscal year from April 1, 2023 to March 31, 2024, was reviewed.

The ADOC acknowledged that the CQI initiative report did not contain a written record of information related to the Resident Satisfaction survey taken in March 2024, including the date the survey was taken, the results of the survey, and how, and the dates when, the results of the survey taken were communicated.

Failure to include the required information in the CQI initiative report could limit opportunities for further collaboration for quality improvement in the home.

Sources: CQI initiative report; and interview with the ADOC.

[740836]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the home's CQI initiative report contained a written record of the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions.

Rationale and Summary
The home's CQI initiative report for the 2023/2024 fiscal year was reviewed.

The ADOC acknowledged that the CQI initiative report did not contain a written record of the actions taken to improve the long-term care home based on the results of the Resident and Family Satisfaction surveys taken in the fiscal year, including the dates the actions were implemented and the outcomes of the actions.

Failure to include the required information in the CQI initiative report could limit opportunities for further collaboration for quality improvement in the home.

Sources: CQI initiative report; and interview with the ADOC.

[740836]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iv.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:

6. A written record of,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

The licensee has failed to ensure that the home's CQI initiative report contained a written record of the role of the continuous quality improvement committee in actions taken under subparagraphs i. and ii.

Rationale and Summary
The home's CQI initiative report for the 2023/2024 fiscal year was reviewed.

The DOC/Administrator and ADOC both acknowledged that the CQI initiative report did not contain a written record of the information, as there was no CQI committee established in the home.

Failure to include the required information in the CQI initiative report could limit opportunities for further collaboration for quality improvement in the home.

Sources: CQI initiative report; and interviews with the DOC/Administrator and ADOC.

[740836]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following

information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the home's CQI initiative report contained a written record of how, and the dates when, the actions taken was communicated to residents, families, Residents' Council, and Family Council.

Rationale and Summary
The home's CQI initiative report for the 2023/2024 fiscal year was reviewed.

The ADOC acknowledged that the CQI initiative report did not contain a written record of how, and the dates when, the actions taken was communicated to residents, families, Residents' Council, and Family Council.

Failure to include the required information in the CQI initiative report could limit opportunities for further collaboration for quality improvement in the home.

Sources: CQI initiative report; and interview with the ADOC.

[740836]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #026 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 CQI initiative report was provided to the Residents' Council and Family Council.

Rationale and Summary
The home's 2023/2024 CQI initiative report was not provided to the Residents' Council and Family Council.

A review of the home's Resident Council Meeting Minutes and Family Council Meeting Minutes over the past 12 months did not include updates related to the CQI initiative report.

The Registered Social Worker (RSW) and Activity Director both acknowledged that the CQI initiative report was not provided to Residents' Council and Family Council.

Failure to provide the home's CQI initiative report may result in residents and family not being aware of the status of the home's CQI initiatives.

Sources: Resident Council Meeting Minutes; Family Council Meeting Minutes; and interviews with RSW and Activity Director.

[740836]

WRITTEN NOTIFICATION: Website

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee failed to ensure that the home's website included the CQI initiative report under subsection 168 (1).

Rationale and Summary
Review of the home's website did not include the 2023/2024 CQI initiative report.

The DOC/Administrator confirmed that the report was not posted on the home's website.

Failure to ensure that the home's website included the CQI initiative report may result in the public being unable to review the home's priority areas, improvements and outcomes.

Sources: Home's website; and interview with the DOC/Administrator.

[740836]