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 29, 2024	
Inspection Number: 2024-1484-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Albright Gardens Homes, Incorporated	
Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville	
Lead Inspector Emily Robins (741074)	**Inspector Digital Signature** Emily C Robins Digitally signed by Emily C Robins Date: 2024.03.14 09:30:12 -04'00'
Additional Inspector(s) Sydney Withers (740735)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 18, 19, 22-26, 29-31, 2024 and February 1, 2024. The inspection occurred offsite on the following date: January 23, 2024.

The following intake(s) were inspected:

- Intake: #00106672 - Proactive Compliance Inspection (PCI) for Albright gardens LTCH.

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

Resident Care and Support Services

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
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. 85 (3) (q)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(q) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;

The licensee failed to ensure the most recent minutes of the Family Council meeting were posted in the home in a conspicuous and easily accessible location.

Rationale and Summary
During the inspection, the most recent minutes of the Family Council meeting were not posted in the home.

Sources: Observations of the LTCH, interviews. [740735]

Date Remedy Implemented: January 25, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 failed to ensure that a copy of the report required under subsection 168 (1) was provided to the Residents' Council and Family Council.

Rationale and Summary
A copy of the report required under subsection 168 (1) was not provided to the Residents' and Family Councils prior to commencement of the inspection. Email records and observations indicated the report was provided to the councils during the inspection.

Sources: Observation of resident information board, email to Family Council Chair, interviews. [740735]

Date Remedy Implemented: January 26, 2024
NC #003 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 failed to ensure that the current version of the visitor's policy was posted in the home.

Rationale and Summary
During the inspection, the home's visitor policy was not posted in the home.

Sources: Observations, Policy: Visiting During COVID-19, and interview [741074].

Date Remedy Implemented: January 19, 2024.

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 their website included the current continuous quality improvement (CQI) initiative report required under subsection 168 (1).

Rationale and Summary
During the inspection, the current report required under subsection 168 (1) was not posted on the home's website.

Sources: Review of LTCH's website on January 23 and 24, 2024, interview. [740735]

Date Remedy Implemented: January 24, 2024

WRITTEN NOTIFICATION: Documentation

NC #005 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 failed to ensure that the provision of the care set out in the plan of care was documented.

1) Rationale and Summary

There was no point-of-care (POC) documentation to support that a resident who was totally dependent on staff for their activities of daily living was dressed for the day or assisted with their personal hygiene on several days in January 2024.

2) Rationale and Summary

There was no point-of-care documentation to support that a resident who was dependent on staff for assistance with their activities of daily living was provided morning care on several days in January 2024. Further, there was no documentation to support that this resident was provided care through the night, as required per their plan of care.

3) Rationale and Summary

There was no point-of-care documentation to support that a resident who was dependent on staff for assistance with their activities of daily living was dressed for the day or assisted with their personal hygiene on several days in January 2024. Further, only one bath was documented for this resident one week in January 2024 and, staff did not document if they had provided assistance with their personal assistance services device (PASD).

Failure to ensure that the care provided to these residents as set out in their plan of care was documented may have diminished the level of accountability of staff providing their care.

Sources: January 2024 POC documentation and interview. [741074]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #006 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 failed to ensure that the actions taken to improve the long-term care home (LTCH), and the care, services, programs and goods based on the results of the survey were documented.

Rationale and Summary
Documentation of the 2022 survey results indicated 20 comments with feedback related to the LTCH's care, services, programs and goods. Three of the 20 comments described actions taken by the LTCH to address the feedback. Documentation of the remaining comments did not demonstrate actions taken in response to these survey results.

Sources: Documentation of 2022 resident and family/caregiver experience survey results and actions, interviews. [740735]

WRITTEN NOTIFICATION: Duty to Respond

NC #007 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.

When the Residents' Council advised the licensee of concerns or recommendations under paragraph 6 of subsection (1), the licensee failed to, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Rationale and Summary
Paragraph 6 of subsection (1) of the Act outlined that the Residents' Council had the power to advise the licensee of any concerns or recommendations the Council had about the operation of the home.

Residents' Council meeting minutes were reviewed and indicated concerns. A written response was not provided to Council regarding these concerns.

Failure to respond in writing to Council's concerns or recommendations within 10 days of receiving the advice diminished staff accountability for responding to and potentially resolving concerns brought forward by the Council. As a result, there was no record of the home's response to Council or any follow-up actions taken in response to their concerns.

Sources: Residents' Council meeting minutes, email correspondence, interviews. [740735]

WRITTEN NOTIFICATION: Doors in a home

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 equipped with locks to restrict unsupervised access to those areas by residents, and that those doors were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
During the inspection, a door leading to a non-residential area in the home was found to be unlocked and unsupervised by staff.

Sources: Observations and interview [741074].

WRITTEN NOTIFICATION: Menu Planning

NC #009 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 failed to ensure a written record was kept of the menu cycle evaluation, including the date of the evaluation and the names of the persons who participated in the evaluation.

Rationale and Summary

The written record of the long-term care home's (LTCH) most recently completed menu cycle evaluation did not include the date the Director of Dietary Services (DDS) and Food Services Manager evaluated the menu or their signatures. Additionally, the written record did not include the registered dietitian's (RD) approval for nutritional adequacy.

Sources: Fall/winter 2023/24 menu cycle evaluation and approval tool, email records, interviews. [740735]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee failed to ensure two residents were provided with an assistive device they required to eat as comfortably and independently as possible.

Rationale and Summary
Two residents required a specific adaptive feeding device at mealtime. During an observation of meal service, neither resident was provided with the adaptive feeding device where it would be required.

Failure to provide these residents with an adaptive feeding device as specified in their plans of care may have impacted their ability to eat as comfortably and independently as possible.

Sources: Meal observation, residents' clinical records, interview. [740735]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure a resident, who required assistance at mealtime, was served a meal when someone was available to provide the required assistance.

Rationale and Summary
A resident required extensive assistance from one staff at mealtime for physical assistance with their meal. During an observation of meal service, the resident was not assisted with their meal for a length of time after they were served their food. The resident did not feed themselves in the interim.

Failure to provide this resident with the required assistance when served their meal may have impacted the quality of their dining experience and their food intake due to temperature changes in their food.

Sources: Meal observation, resident's clinical record, policy "Pleasurable Dining Service" (reviewed December 2016), interview. [740735]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed about an outbreak of a disease of public health significance or communicable disease.

Rationale and Summary

Niagara Region Public Health declared the home to be in a COVID-19 outbreak on January 6, 2024. This outbreak was reported to the Director on January 8, 2024. The Ministry of Long-term Care's after hours reporting line was not contacted about the outbreak.

Sources: Critical Incident Report and interview [741074].

WRITTEN NOTIFICATION: Medication Management System

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure a written policy within their medication management system was implemented.

Rationale and Summary
A) The home's drug destruction and disposal policy directed staff to remove medication from packaging before placing it in the disposal bin and required the drug destruction process to be initiated once the bin was three quarters full. During the inspection, four drug disposal bins were found to be filled to the top of the bin, with some of the drug content remaining in packaging.

Failure to remove drugs from their packaging prior to disposing or leave a quarter of the disposal bin empty may have have interfered with the efficacy of the drug destruction process.

Sources: Observations of maintenance storage room and drug disposal bins, Policy "Medication Destruction and Disposal (Non-Narcotic/Controlled Medications)" (reviewed June 30, 2023), interviews. [740735]

B) The home's drug destruction and disposal policy required registered nursing staff to check medication storage areas on a regular basis to identify expired medication for disposal. During the inspection, three containers of expired medication were observed in a government drug supply storage area within one of the home's medication rooms.

Failure of registered nursing staff to identify drug supply to be disposed increased the risk of expired medication being administered to a resident.

Sources: Observation of the second floor medication room, Medication Cart Audit Form, Policy "Medication Destruction and Disposal (Non-Narcotic/Controlled Medications)" (reviewed June 30, 2023), interviews. [740735]

C) The home's drug destruction and disposal policy required registered nursing staff to check medication storage areas on a regular basis to identify medication that were not appropriately packaged. During the inspection, a box of medication with an illegible label was observed in a drug supply storage area within one of the home's medications rooms.

Failure of registered nursing staff to identify a drug with an illegible label for disposal posed a minimal risk to resident health and safety, as there was no resident identifier on the label to direct staff on medication administration.

Sources: Observation of the second floor medication room, Policy "Medication Destruction and Disposal (Non-Narcotic/Controlled Medications)" (reviewed June

30, 2023), interview. [740735]

D) The home's drug destruction and disposal policy required registered nursing staff to place medication to be disposed of in a container dedicated for disposal. During the inspection, a medication incident form for an incident that occurred on a specified date in 2023 was found to include a medication cup that was folded and taped to the medication incident form containing six medication tablets.

The form was stored in a filing cabinet within the Chief Nursing Officer's (CNO) office, which was only accessible by the CNO and Administrator.

Failure of registered nursing staff to follow the home's drug disposal process for an omitted medication posed minimal risk to resident health and safety.

Sources: Policy "Medication Destruction and Disposal (Non-Narcotic/Controlled Medications)" (reviewed June 30, 2023), medication incident form (July 15, 2023), interviews. [740735]

E) The home's drug destruction and disposal policy required registered nursing staff to ensure any controlled substance to be destroyed and disposed of was securely stored in a one-way access, double-locked box in the medication room or other secure area within the home, only accessible by nursing staff.

During the inspection, it was noted that the medication was accessible to non-nursing staff as well.

Failure of registered nursing staff to follow the home's drug disposal process for an omitted controlled substance led to the drug not being stored in a double-locked area until disposal.

Sources: Policy "Destruction and Disposal of Narcotic and Controlled Medications" (reviewed June 30, 2023), medication incident form, interviews. [740735]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee failed to ensure steps were taken to ensure the security of the drug supply, including locking an area where drugs were stored at all times, when the area was not in use.

Rationale and Summary
A storage area for the government drug supply was located in an office within the administration wing of the long-term care home (LTCH). The door to the office was observed to be unlocked and open on multiple occasions and the key to access the cabinet where the drugs were stored in the office was kept in the keyhole. The door to the administration wing of the LTCH was not locked during business hours.

Failing to ensure a drug storage area was not locked at all times increased the risk that residents or individuals who were not to have access to the drug supply may have been able to access the drugs.

Sources: Observation of drug storage area, interview. [740735]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2.

Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
2. Access to these areas shall be restricted to,
i. persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.

The licensee failed to ensure steps were taken to ensure the security of the drug supply, including restricting an area where drugs were stored to the following individuals:

a) Persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home; and

b) The Administrator.

Rationale and Summary

A) A storage area for drugs to be disposed was located in a maintenance room, accessible by maintenance and housekeeping staff. Seven drug disposal bins were observed with drug contents recognizable and in their whole form.

Failing to ensure access to drug storage areas were restricted only to the individuals as set out in the legislation led to staff who were not qualified to access drugs in the home overseeing the storage of drugs to be disposed.

Sources: Observations of maintenance storage room and drug disposal bins, interviews. [740735]

B) A storage area for government drug supply was located in an unlocked cabinet within the office of a staff member who did not meet the criteria listed under paragraph 2 of section 139.

Failing to ensure access to drug storage areas was restricted only to the individuals as set out in the legislation led to staff who were not qualified to access drugs in the home overseeing the supply and storage of the government drug supply.

Sources: Observation of drug storage area, interviews. [740735]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
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,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee failed to ensure a medication incident involving a resident was reported to the resident or their substitute decision maker (SDM).

Rationale and Summary
A medication incident that occurred on a specified date in 2023 was not reported to the resident or their SDM.

There was low risk posed to the resident and their SDM when they were not made aware of a medication incident involving the resident.

Sources: Resident's clinical record, medication incident form, interview. [740735]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a) (i)
Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,
(i) reduce and prevent medication incidents and adverse drug reactions,

The licensee failed to ensure a quarterly review was undertaken of all medications incidents.

Rationale and Summary

Sixteen medication incidents that occurred between July and September 2023 were not reviewed by the home's Professional Advisory Committee (PAC).

Failure to do so posed a risk that trends may not have been identified and appropriate follow-up actions not taken.

Sources: PAC Pharmacy Report, medication incident quarterly review, interview. [740735]

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 148 (3) (b)

Drug destruction and disposal

s. 148 (3) The drugs must be destroyed by a team acting together and composed of,

(b) in every other case,

(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and

(ii) one other staff member appointed by the Director of Nursing and Personal Care.

O. Reg. 246/22, s. 148 (3); O. Reg. 66/23, s. 31.

The licensee failed to ensure drugs were destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care.

Rationale and Summary

The Chief Nursing Officer (CNO) had not appointed a nursing staff or one other staff member to complete the drug destruction process. A maintenance Worker confirmed that they remove the full disposal bins from the medication rooms and store the bin in a maintenance room until removal from the long-term care home (LTCH).

By not having an appointed team to destroy drugs to be disposed of, the drugs remained in their whole form, increasing the risk of drugs being accessed before removal from the LTCH.

Sources: Observations of maintenance storage room and drug disposal bins, Policy "Medication Destruction and Disposal (Non-Narcotic/Controlled Medications)"

(reviewed June 30, 2023), interviews. [740735]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #019 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 failed to ensure the continuous quality improvement (CQI) committee was composed of at least one member of the home's Residents' Council.

Rationale and Summary
The Chief Executive Officer (CEO), the home's designated lead for the home's CQI initiative, acknowledged that the CQI committee did not include at least one member of the home's Residents' Council.

Failing to include at least one member of Residents' Council on the CQI committee may have led to less opportunity for direct resident input into the home's quality improvement initiatives.

Sources: CQI Meeting Minutes and interview. [740735]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
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 failed to ensure that the report required under subsection 168 (1) included a written record of 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 and members of staff of the home.

Rationale and Summary

The home's CQI report for the fiscal year ending March 31, 2023 did not include a written record of how, and the dates when, the results of the survey taken in 2022 were communicated to the required stakeholders.

Sources: 2023 CQI Report and interview. [740735]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #021 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 failed to ensure the report required under subsection 168 (1) included a written record of the actions taken to improve the long-term care home (LTCH), 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 report for the fiscal year ending March 31, 2023 did not include a written record of actions taken to improve the LTCH based on the results of the survey taken in 2022, the required dates or outcomes of the actions.

Sources: 2023 CQI Report and interview. [740735]

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) 6. ii.
Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licensee failed to ensure the report required under subsection 168 (1) included a written record of any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions.

Rationale and Summary

The home's CQI report for the fiscal year ending March 31, 2023 did not include a written record of any other actions taken to improve the LTCH in the home's priority areas for quality improvement during the 2022/2023 fiscal year, the required dates or outcomes of the actions.

Sources: 2023 CQI Report and interview. [740735]

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. iii.
Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

The licensee failed to ensure that the report required under subsection 168 (1) included a written record of the role of the Residents' Council and Family Council in actions taken under subparagraphs i and ii.

Rationale and Summary

The home's CQI report for the fiscal year ending March 31, 2023 did not describe the role of either council in actions taken under subparagraphs 168 (2) 6. i and ii.

Sources: 2023 CQI Report and interview. [740735]

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 failed to ensure the report required under subsection 168 (1) included a written record of the role of the continuous quality improvement (CQI) committee in actions taken under subparagraphs i and ii.

Rationale and Summary

The home's CQI report for the fiscal year ending March 31, 2023 did not include a written record of the role of the CQI committee in actions taken under subparagraphs 168 (2) 6 i and ii.

Sources: 2023 CQI Report and interview. [740735]

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 failed to ensure the report required under subsection 168 (1) included a written record of 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 and members of the staff of the home.

Rationale and Summary

The home's CQI report for the fiscal year ending March 31, 2023 did not include a written record of how, and the dates when, the actions taken under subparagraphs 168 (2) 6. i and ii were communicated to the required stakeholders.

Sources: 2023 CQI Report and interview. [740735]