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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Public Report

Report Issue Date: December 12, 2024

Inspection Number: 2024-1377-0006

Inspection Type:
Proactive Compliance Inspection

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Halton Hills, Georgetown

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 6-8, 13-14, 19-22, 25-28, 2024

The following intake was inspected:

- Intake #00130744, related to a 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
Medication Management
Residents' and Family Councils
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: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident was reassessed and their plan of care was reviewed and revised when their care needs changed.

Rationale and Summary

A resident's plan of care did not reflect the current type of diet that was being provided to the resident.

On November 7, 2024, the resident's plan of care was updated to reflect the correct diet type.

Sources: a resident's clinical health records, meal observations and interviews with a Personal Support Worker (PSW), a Dietary Aide (DA), the Dietary Manager (DM), and the Registered Dietician (RD).

Date Remedy Implemented: November 7, 2024

NC #002 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; and

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

Rationale and Summary

During the initial tour of the home, a Long-Term Care Homes (LTCH) Inspector noted that an explanation of the protections afforded under section 30 was not posted in the home.

On November 7, 2024, a signage titled Whistleblower Reporting which included a general explanation of the protections afforded under section 30 was posted on the home's bulletin board.

Sources: LTCH Inspector's observation, e-mail correspondence from Extendicare Corporate, and an interview with the Director of Care (DOC).

Date Remedy Implemented: November 7, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

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:

4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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 those changes were implemented.

The licensee has failed to ensure that the written record of Skin and Wound Management and Pain Management program evaluations included the date of the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary

The annual evaluation of the home's Skin and Wound Management and Pain Management programs did not include the date of the evaluation, a summary of the changes made to improve resident outcomes and the dates when those changes were implemented.

On November 27, 2024, the above program evaluations were revised to include the required information.

Sources: the home's Skin and Wound Management Program and Pain Management Program evaluations, and an interview with the Assistant Director of Care (ADOC).

Date Remedy Implemented: November 27, 2024

NC #004 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 issued by the Director was followed by staff.

Rationale and Summary

According to the additional requirement under section 7.3 (b) of the IPAC Standard the licensee shall ensure that audits are performed regularly, at least quarterly, to ensure that all staff can perform the IPAC skills required of their role.

The home's Hand Hygiene (HH) and donning and doffing of Personal Protective Equipment (PPE) audits did not include the names of the staff members audited, as required.

On November 21, 2024, the ADOC indicated that the name of the staff members who were being audited would be captured moving forward.

Sources: the home's HH and PPE audits and interviews with the ADOC and the IPAC Consultant.

Date Remedy Implemented: November 21, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 27.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
27. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

The licensee has failed to ensure that a resident's right to be informed in writing of the policy affecting one of their activities of daily living (ADLs), was respected.

Rationale and Summary

A resident had restrictions regarding one of their ADLs and was not informed of any policy or rule affecting their ADL.

By not providing the resident with the policy or rule restricting one of their ADLs, the resident was not aware of the reason for the restrictions and remained dissatisfied with the home's communication process.

Sources: a resident's clinical health records, the home's email correspondence, and interviews with a resident, a Registered Practical Nurse (RPN), the Administrator and the DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided

to the resident as specified in the plan.

The licensee failed to ensure that the care set out in a resident's written plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A resident's written plan of care documented specific directions related to one of their nutritional interventions.

On occasion, these directions were not followed.

When staff did not follow the resident's plan of care, there was potential risk of harm to the resident.

Sources: a resident's clinical health records, LTCH Inspector's observation and interviews with staff.

WRITTEN NOTIFICATION: Air temperature

NC #007 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 air temperature was measured and documented in writing, at a minimum in at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home, and any designated cooling area.

Rationale and Summary

The home's air temperature record on a 20-day period, showed that on multiple occasions, the air temperature was not measured and recorded on two resident bedrooms in two different parts of the home, and in the lounges or the designated cooling areas in all Resident Home Areas (RHAs).

By not measuring and recording the air temperatures as required, there was a risk that staff could not implement interventions in a timely manner if the air temperature would fall below 22 degrees Celsius.

Sources: the home's air temperature record, and interviews with the Environmental Services Manager (ESM) and the DOC.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff used a resident's equipment in accordance with the manufacturer's instructions.

Rationale and Summary

The manufacturer's instructions for a resident's equipment documented possible risks for injury when the equipment was not used for its designed purpose.

On multiple occasions, staff used a resident's equipment for a purpose not specified in the manufacturer's instructions for use and without being aware of the associated risks. On a separate occasion, the resident's family used the resident's equipment improperly, without being informed of the potential risks.

Staff not following the manufacturer's instructions regarding the use of a resident's equipment, put the resident's safety at risk.

Sources: a resident's clinical health records, the manufacturer's manual for the resident's equipment, last revised in 2023, and interviews with the resident and staff.

WRITTEN NOTIFICATION: General Requirements for Programs

NC #009 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 an intervention provided to a resident under

the Skin and Wound program and the resident's responses to this intervention were documented.

Rationale and Summary

A resident's plan of care directed staff to provide a specific intervention related to their skin and wound care.

There was no documentation in the resident's plan of care of this intervention and the resident's responses to this intervention.

By not documenting the intervention provided to the resident and their responses as required, staff may not provide this intervention consistently and made it difficult to evaluate its effectiveness.

Sources: a resident's clinical health records, and interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 4.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
4. Treatments and interventions, including physiotherapy and nutritional care. O. Reg. 246/22, s. 55 (1).

The licensee has failed to comply with the procedure related to treatment and interventions for a resident's wounds.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that their skin and wound care program includes treatment and interventions for wounds and is complied with.

Rationale and Summary

The home's Skin and Wound Care policy documented that the treatment regimen for any altered skin integrity was to be documented in the electronic treatment administration (eTAR) and/or in the electronic medication administration record (eMAR). Staff were to follow the protocols for management of altered skin integrity areas and use clinically appropriate assessment tools, such as Wound Assessment, for pressure injuries/venous stasis or ulcers of any type and Impaired Skin Integrity Assessment, for all other skin impairments.

i) On one-week period, there was no documentation in a resident's eTAR of the treatment applied to one of their areas of skin injury and it was unclear what treatment and how often the treatment was applied.

On a six-week period, despite the continuous deterioration of the resident's skin injury and the identification of a new wound, staff did not use the appropriate assessment tool to assess the resident's wounds. Multiple assessments completed during this period, did not include required information as specified in the home's policy for wound assessments.

ii) On a separate occasion, over a two-week period, staff did not complete the appropriate assessment tool to assess the resident's new wound. Additionally, there was no documentation in the resident's eTAR of the treatment applied to this wound.

The ADOC and the DOC said staff should have followed the home's protocols for treatments and assessments of resident's wounds as indicated in the home's policy.

Gaps in following the home's protocols for assessments and treatment of a resident's wounds might have contributed to the deterioration of their wounds.

Sources: a resident's clinical health records, the home's skin and wound care policy, and interviews with the ADOC, the DOC and other staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate interventions to reduce pain, promote healing and prevent infection of their wounds.

Rationale and Summary

A resident was identified with a skin injury. Over one-week period, staff did not apply the treatment as specified in the home's protocol for skin and wound. The resident's wound deteriorated and required treatment for wound infection.

On a separate occasion, the resident was noted with signs of infection of their wounds. Despite the recommendations of the home's Enterostomal (ET) nurse, there was a delay in starting the treatment.

Over one-month period, on multiple occasions the resident was noted with pain during the dressing change and assessments of their wounds. Despite directions to administer the resident's pain medication at a specific time before the dressing change, staff did not follow these directions, resulting in a delay to reduce or relieve the resident's pain.

The home's DOC said staff should have followed the home's skin and wound care treatments and pain management procedures.

By not providing immediate interventions to promote healing, prevent infection and reduce pain, increased the risk associated with unrelieved pain and deterioration of the resident's wounds.

Sources: a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #012 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 a resident was assessed by a Registered

Dietician (RD) in relation to their pressure injury.

Rationale and Summary

A resident was identified with a pressure injury.

The resident's pressure injury continued to deteriorate over one-week period and no referrals were sent to the RD regarding the deterioration of the resident's wound.

By not assessing the resident's nutritional needs in relation to their pressure injury, appropriate nutritional interventions could not be implemented.

Sources: a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Pain management

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee has failed to comply with the communication and assessment methods within their pain management program in relation to a resident's pain.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that their pain management program includes communication and assessment methods for residents who are unable to communicate their pain or who are cognitively

impaired and is complied with.

Rationale and Summary

The home's Pain Identification and Management policy documented that Pain Assessment in Advanced Dementia (PAINAD) was to be used to assess the severity of pain for all non-verbal and cognitively impaired residents.

A resident was unable to rate their pain due to their limited cognitive abilities. On two separate occasions over a three-week period, staff did not use the PAINAD assessment tool to assess the resident's severity of pain.

By using the incorrect pain assessment tool, the severity of the resident's pain could not be accurately assessed and increased the risk that appropriate interventions might not be implemented to relieve or reduce the resident's pain.

Sources: a resident's clinical health records, the home's Pain Identification and Management policy, and interviews with staff.

WRITTEN NOTIFICATION: Pain Management

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by the initial interventions, the resident's pain was assessed.

Rationale and Summary

A resident had pain related to their wounds and their plan of care directed staff to complete a comprehensive pain assessment when the wound assessments were completed.

On three separate occasions, the resident had pain despite their scheduled pain medications being administered.

No comprehensive pain assessments were completed on any of these occasions when the resident's pain was not relieved by the initial pain management interventions.

By not assessing the resident's pain when their pain was not relieved by the initial interventions, staff could not implement appropriate actions to manage the resident's pain and it made it difficult to evaluate the effectiveness of the interventions provided.

Sources: a resident's clinical health records and interviews with the ADOC, and the DOC.

WRITTEN NOTIFICATION: Menu Planning

NC #015 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 that a written record was kept of the menu cycle evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, and the date that the changes were implemented.

Rationale and Summary

The home's fall/winter 2024 menu cycle evaluation did not include the date of the evaluation, the name of the Dietary Manager who participated in the evaluation, and the date that the changes were implemented, as required.

Sources: Menu review and approval tool for fall/ winter 2024, and interviews with the DM and the RD.

WRITTEN NOTIFICATION: Menu Planning

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary

On one occasion, three planned menu items were not offered and available to residents during a meal service on one of the Resident Home Areas (RHAs).

By not offering the planned menu items, the residents' expectations on the food items to be offered and available, were not met.

Sources: LTCH Inspector's observations, Fall/ Winter Menu 2024-2025 menu, standardized recipe, and interviews with a Dietary Aide, a Cook, and the DM.

WRITTEN NOTIFICATION: Food Production

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee failed to ensure that the organized food production system in the home provided for communication to residents and staff of any menu substitutions.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that the organized food production system in the home was complied with.

Rationale and Summary

The home's Menu Substitutions policy indicated that the dietary department lead or designate will record the menu substitutions on the daily menu posted in the resident home areas.

On one occasion, the menu substitutions for three food items, were not recorded on the daily menu posted on one of the RHAs.

By not communicating the menu substitutions to the residents and staff through the posted daily menu, the residents may have expected to choose from the planned menu items that were not available.

Sources: LTCH Inspector's observations, the home's Menu Substitutions policy, Fall/ Winter Menu 2024-2025, daily menu, standardized recipe and interviews with a DA, a Cook, and the DM.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #018 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 the Infection Prevention and Control (IPAC) Standard issued by the Director was followed by staff.

Rationale and Summary

According to the additional requirement under section 9.1 of the IPAC Standard, the licensee shall ensure that hand hygiene, including, but not limited to, at the four moments of hand hygiene before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact) were followed.

On one occasion, a PSW student did not follow the four moments of hand hygiene

after touching soiled items and before and after contact with residents.

By not performing hand hygiene as required, there was an increased risk of microorganisms transmission among the residents and staff.

Sources: LTCH Inspector's observation, and interviews with a PSW student and staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

Following a medication administration incident, a resident's prescriber's order documented specific directions for staff when administering the resident's medication.

On a separate occasion, staff did not follow the prescriber's directions for use and the resident did not receive the medication as prescribed. As a result, the resident had symptoms associated with the improper medication administration.

The DOC said staff were expected to follow the prescriber's directions for use when

administering the resident's medication.

Staff not ensuring the prescriber's directions for use were followed put the resident at risks associated with improper medication administration.

Sources: a resident's clinical health records, and interviews with the resident and staff.

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 (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 failed to ensure that the home's Continuous Quality Improvement (CQI) committee was composed of every designated lead of the home.

Rationale and Summary

The home's Administrator/CQI Lead indicated that CQI committee did not include the Personal Support Worker as a member.

Failure to include every designated lead of the home in the CQI committee was a missed opportunity for relevant interdisciplinary feedback pertaining to CQI

initiatives.

Sources: CQI committee meeting minutes, and interviews with the Administrator/CQI Lead.

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) 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 Continuous Quality Improvement (CQI) initiative report contained 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 families and members of the staff of the home.

Rationale and Summary

The home's CQI initiative report did not include the dates when the results of the resident and family experience survey were shared to the families and members of the staff of the home.

The home's Administrator/CQI Lead and stated that they do not have records of

whether the results of the survey were shared as required.

Sources: the home's CQI initiative report; Interview with the Administrator/CQI Lead.

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. 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 that the Continuous Quality Improvement (CQI) initiative report contained a written record of how, and the dates when, the actions taken under O. Reg. 246/22, s. 168 (2) 6 (i) and (ii) were communicated to the resident council, families and members of the staff of the home.

Rationale and Summary

The home's CQI initiative report did not include the record of how and the date when the actions taken by the home were shared to the resident council, families and members of the staff of the home.

The home's Administrator/CQI Lead and stated that they did not have records of whether the above actions taken by the home were shared as required.

Sources: The home's CQI initiative report and interviews with the Administrator/CQI Lead.