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: February 26, 2024	
Inspection Number: 2024-1055-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare London, London	
Lead Inspector Tatiana McNeill (733564)	**Inspector Digital Signature** Tatiana McNeill Digitally signed by Tatiana McNeill Date: 2024.02.26 14:36:15 -05'00'
Additional Inspector(s) Julie Lampman (522) Inspector Iqbal Kalsi (743139) was also present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 29, 30, and 31, 2024 and February 1, 2, 5, 6, and 7, 2024

The following intake(s) were inspected:

- Intake: #00106631 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management

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

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (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 has failed to ensure that when a resident was reassessed for the use of a specialized equipment, that their care plan related to toileting was reviewed and revised.

Rationale and Summary
The resident's care plan indicated that staff were to provide specific care and specialized equipment for the resident's toileting routine.

A Personal Support Worker (PSW) stated that the resident no longer required certain equipment.
A Registered Practical Nurse (RPN) stated the resident's care plan should have been updated when they were assessed to use a specialized equipment. The RPN updated the resident's care plan to reflect the resident's individual requirements for continence care.

Sources: Review of the resident's clinical record and interviews with PSW, and RPN. [522]

Date Remedy Implemented: February 2, 2024

NC #002 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 has failed to ensure that a resident was reassessed and their care plan reviewed and revised when the resident's care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary
The resident's care plan indicated that the resident was to wear a device.

The resident stated that they did not wear a device as it was no longer required. A Registered Practical Nurse (RPN) confirmed that the resident did not wear a device and updated the resident's care plan.

Sources: Review of the resident's clinical record and interviews with the resident, RPN, and other staff.
[522]

Date Remedy Implemented: February 2, 2024

NC #003 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 has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the resident no longer used their assisted device.

Rationale and Summary
The resident's care plan indicated that the resident was to wear an assisted device at all times. On three occasions during the inspection, Inspector #522 observed that the resident was not using their assisted device.

A Personal Support Worker (PSW) stated they had only been working with the resident for a few days and had noted the resident's care plan stated the resident

was to use an assisted device. The PSW stated they had searched for the resident's assisted device but could not find them and they asked another PSW who told them that the resident no longer required an assisted device. The resident's care plan was updated to indicate the resident no longer required the use of an assisted device.

Sources: Observations of the resident, review of the resident's clinical record and interviews with PSW and other staff.
[522]

Date Remedy Implemented: February 5, 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 implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes section 6.1 states, the licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions. During the inspection Inspectors #733564 and #522 observed the following:

A) A resident's room had contact precautions posted. The isolation caddy outside the resident's room had only one gown. A Personal Support Worker (PSW) stated that the isolation caddy should have been stocked with gowns and PSW replenished the cart.

B) Another resident's room had contact precautions posted. The isolation caddy outside the resident's room had blue gloves placed loosely inside one of the drawers. A Registered Practical Nurse (RPN) stated the gloves should remain in the boxes and should not be placed loosely in the isolation caddy drawers. The RPN removed the gloves from the isolation caddy drawer.

C) A resident's room had droplet and contact precautions posted. The isolation caddy outside the resident's room did not have any N95 masks and the alcohol-based hand rub (ABHR) had an expiry date of August 2022. A PSW stated there was no room on the caddy to place the N95 masks and stated that it was the responsibility of the registered staff to stock the isolation caddies. The isolation caddy was later stocked with N95 masks and the expired ABHR was removed.

D) Another resident's room had droplet and contact precautions posted. The box of N95 masks on the isolation caddy was empty. The isolation caddy was later stocked with N95 masks.

E) The second floor Resident Safety Supply and IPAC Supply Room had two bottles of ABHR with an expiry date of August 2022.

F) The garbage bin outside a resident's room had a yellow isolation gown hanging out of the garbage with the lid open. Inspector #522 spoke with the Administrator who stated that staff should ensure gowns were put inside the garbage bin with the lid closed and if the bin was too full then it should be emptied. At that time, a PSW came, put on gloves, pushed down the gowns and closed the lid.

There was risk of potentially spreading healthcare associated infections when the licensee did not have the PPE supply and stewardship plan in place to ensure that adequate access to PPE for Routine Practices and Additional Precautions was available, and accessible to staff and residents, and ensure that the ABHR was before the expiration date.

Sources: IPAC observations of the home, review of the IPAC Standard for Long-Term Care Homes dated April 2022, and interviews with PSW, PSW, RPN, the IPAC Manager and the Administrator.
[522]

Date Remedy Implemented: January 29, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked medication room.

Rationale and Summary
During the inspection, the medication fridge in the medication room where controlled substances were stored was observed not to have a lock. Controlled substances were stored in a locked box within the fridge.

Director of Care (DOC) stated they thought since the medication room was locked that the medication fridge where the controlled substances were stored did not require a lock.

Later during the inspection, the medication fridges where controlled substances were stored were equipped with locks.

Sources: Observation of medication storage areas, and interviews with DOC #104 and DOC.
[522]

Date Remedy Implemented: February 7, 2024

WRITTEN NOTIFICATION: Residents' Rights

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
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:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that a resident's personal health information (PHI) within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

Rationale and Summary
During an initial tour of the home, Inspector #522 and Inspector #733564 observed the following:

A) A Point of Care (POC) tablet was sitting on a table with the POC screen open and unattended with resident information visible.

B) A POC tablet was sitting on a table outside the nurses' station. The POC screen was left open and unattended with documentation for a resident visible. A Personal Support Worker (PSW) confirmed they had left the screen open and should have locked the screen when they left the tablet unattended.

There was a potential risk of a breech of residents' PHI when staff left the POC screen open with PHI visible in the hallway.

Sources: Observations of the home, and interviews with PSW, RPN and the Administrator.
[522]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (3)
Plan of care
s. 6 (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, mental health, nutritional, dietary, recreational, social, palliative, restorative, religious and spiritual care.

The licensee has failed to ensure that the plan of care covers all aspects of care, including nutritional and dietary care for a resident.

Rationale and Summary
Record review of Point Click Care (PCC) report noted a resident was at a specific nutrition risk.

Review of dietary binder located in the dining room noted that the resident required therapeutic interventions.

Record review of the resident's clinical records noted that their nutrition risk was not included in the care plan. Additionally, their required therapeutic interventions were not included in their care plan.

In an interview, the Nutrition Manager confirmed that the resident's plan of care should have included their nutrition risk and therapeutic interventions, but it did not.

There was potential risk to the resident when their nutrition risk and therapeutic interventions were not included in the plan of care.

Sources: Review of clinical records for the resident and interview with Nutrition Manager.
[733564]

WRITTEN NOTIFICATION: Plan of Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 has failed to ensure that a resident was reassessed and their plan of care reviewed and revised to reflect that the resident required the use of a special aid for oral care.

Rationale and Summary
The resident's family member had expressed concerns related to the resident's oral care. The resident's plan of care indicated that staff were to provide oral care to the resident using a toothbrush.

A Personal Support Worker (PSW) stated they used a special aid for the resident's oral care as it was very difficult to perform regular oral care for the resident due to their health condition.

A Registered Practical Nurse (RPN) acknowledged that the resident had a health condition that prevented them from receiving regular oral care and their care plan should have include the use of a special aid for oral care.

By not revising the resident's care plan when their care needs changed affected new staff members ability to provide the proper care to the resident.

Sources: Observations of the resident, review of the resident's clinical record, and interviews with the resident's family member, PSW, RPN and other staff.
[522]

WRITTEN NOTIFICATION: Policies and Records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (a)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the

plan, policy, protocol, program, procedure, strategy, initiative or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and

The licensee has failed to ensure that their "Zero Tolerance of Abuse and Neglect: Response and Reporting" policy and "Critical Incident Reporting (ON)" policy were in compliance with and implemented in accordance with all applicable requirements under the Act.

Rationale and Summary
FLCTA 2021 s. 25 (1) states, "every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents."

FLCTA 2021 s. 25 (2) states, "at a minimum, the policy to promote zero tolerance of abuse and neglect of residents contain an explanation of the duty under section 28 to make mandatory reports."

The home's "Zero Tolerance of Abuse and Neglect Program" policy indicated that the "Critical Incident Reporting (ON)" policy was a supplemental policy. The home's "Critical Incident Reporting (ON)" policy referenced the duty to make mandatory reports as per the Long-Term Care Homes Act (LTCHA) 2007, s. 24 (1), instead of the Fixing Long-Term Care Act (FLTCA) 2021, s. 28 (1).

The policy indicated that the home would report and submit all mandatory and critical incidents to the Ministry of Health and Long-Term Care (MOHLTC), instead of the Ministry of Long-Term Care and that the Ministry of Health (MOH) Director was to be informed immediately of abuse and neglect of a resident. The policy also referenced reporting critical incidents under LTCHA r. 107 instead of Ontario Regulation 246/22 s. 115.

The home's "Zero Tolerance of Abuse and Neglect: Response and Reporting" policy, Addendum 2 "Jurisdictional Reporting Requirements" referenced the duty to make mandatory reports as per the LTCHA 2007 s. 24 (1) and that abuse and neglect of a resident must be immediately reported to the Director of the MOHLTC.

The Administrator reviewed the policies with Inspector #522 and acknowledged that they had not been updated with the current legislative references and that the name of the Ministry was not correct. The Administrator stated the home's policies were reviewed and updated by the Corporate office.
Although the home had not updated the correct legislative references and the name of the Ministry of Long-Term Care (MLTC), the reporting requirements in the policies were correct.

Sources: Review of the home's Zero Tolerance of Abuse and Neglect Program Policy RC-02-01-01 last reviewed November 2023; the home's Critical Incident Reporting (ON) Policy RC-09-01-06 last reviewed November 2023; the home's Zero Tolerance of Abuse and Neglect: Response and Reporting Policy RC-02-01-01 last reviewed November 2023, Addendum 2: Jurisdictional Reporting Requirements, and an interview with the Administrator.
[522]

WRITTEN NOTIFICATION: Doors in a Home

NC #010 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 has 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 those doors were closed and locked when they were not being supervised by staff.

Rationale and Summary
During an initial tour of the home Inspector #522 and Inspector #733564 observed the following:

A) The door to the kitchen was left open from the resident dining room. There were residents seated off the dining room in the lounge area.

B) The Janitor's room door was unlocked on two separate occasions. Residents were observed seated in the area and a couple of residents were seated in wheelchairs right beside the unlocked Janitor room. Chemicals used for cleaning and disinfecting were noted to be stored in the room.

C) The Resident Safety Supply and Infection Prevention and Control (IPAC) Supply room door was left unlocked. The room was just off the resident TV area where several residents were seated in wheelchairs watching TV.
The room housed the telephone box, fire alarm box, cable box, and electrical boxes which were open and accessible. Two bottles of alcohol-based hand rub and several containers of disinfecting wipes were stored on the shelves and there was a wall with several charging stations. A Registered Nurse (RN) stated that the door did not have a lock on it, and it was always open.

D) Another Janitor's room door was left wide open with cleaning supplies accessible. A resident was seated in a wheelchair right beside the open door and other residents were in the area. A Housekeeping Staff (HS) was observed coming out of soiled utility room. HS stated they did not have an individual key to the Janitor's room. HS stated that the only key to the Janitor's room was locked in the

soiled utility room, which is why they had left the door open when they went to dispose of items in the soiled utility room. HS stated the Janitor's room used to have a keypad but that was removed a few days ago, to put on the Resident Safety Supply and IPAC Supply room door. HS stated that the key to the Janitor room door on another floor was also locked in the soiled utility room on that floor.

There was risk to residents by not having a lock on the Resident Safety Supply and IPAC Supply Room and by leaving the Janitor rooms unlocked as these rooms were in resident areas and not always supervised by staff, and there were chemicals accessible to residents.

Sources: Observations in the home, and interviews with HS, RN, the Support Services Manager and the Administrator.
[522]

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 (1) 3.
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:
3. Monitoring of all residents during meals.

Rationale and Summary
Observations of meal service noted four residents were left unattended in the dining room while they were consuming their breakfast.

In an interview, a Registered Practical Nurse (RPN) stated that the residents should have been monitored during their meal.

In an interview, the Nutrition Manager confirmed that a registered staff should have been present in the dining room while residents were consuming their breakfast.

There was potential risk to residents left unattended while consuming their breakfast in the dining room.

Sources: Observations of meal service in the dining room, interview with RPN and Nutrition Manager.
[733564]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

Rationale and Summary
Record review of food temperatures at point of service taken in the dining room for the month of January 2024, August and September 2023, noted that the temperature of hot foods at point of service was above 180 degrees Fahrenheit.

In an interview, the Nutrition Manager confirmed that the food temperatures taken in the dining room at point of service for the month of January 2024, August and September 2023, were above 180 degrees Fahrenheit. The Nutrition Manager stated that these temperatures were considered to be above the temperatures that were safe and palatable to the residents.

The Nutrition Manager stated that the home had developed a process to ensure that the temperature of hot foods at point of service were safe and palatable to the residents.

Sources: Record review of hot food temperatures taken at Point of Service in the dining room, and interview with Nutrition Manager.
[733564]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #013 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.

Rationale and Summary
A resident was observed to have a meal served to them before someone was available to provide assistance with eating. Observations of meal service noted that a staff member provided assistance with eating to the resident after they provided assistance with feeding to another resident.

Review of the resident's care plan indicated they required assistance with eating. A Personal Support Worker (PSW) and the Nutrition Manager acknowledged that the home's expectation was that staff members were to serve the food to the resident when they were able to provide feeding assistance.
There was risk that the resident's meal could be cold and unpleasant when their meal had been served, but they were waiting for someone to come and provide the

assistance they required.

Sources: Dining observations, record review for the resident, and interview with PSW and Nutrition Manager.
[733564]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

Rationale and Summary
Observations completed during the inspection noted a Personal Support Worker (PSW) leaving a resident's room while carrying soiled linen in their hands, disposing the soiled linen in the laundry hamper, and then returning into the resident's room without performing hand hygiene.

In an interview, Infection Prevention and Control Manager (IPAC) stated that the PSW should have performed hand hygiene after carrying soiled linen into their hands, and prior to returning to the resident's room.

Staff not implementing the home's IPAC program by not performing hand hygiene put residents and staff at risk of potentially spreading healthcare associated

infections.

Sources: IPAC Observations, interview with PSW and IPAC Manager.
[733564]

WRITTEN NOTIFICATION: Medication Management System

NC #015 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 has failed to ensure that the home's "Management of Insulin, Narcotics and Controlled Substances" policy developed for the medication management system to ensure the accurate destruction and disposal of all drugs used in the home was implemented.

Rationale and Summary
The home's "Management of Insulin, Narcotics and Controlled Substances" policy stated that drug destruction should take place every four to six weeks at a minimum. The frequency of drug destruction/disposal should be established with the pharmacist based on the volume of medications awaiting drug destruction/disposal.

Inspector #522 observed a storage box for controlled substances for destruction in the medication room on one of the floors in the home. The box was full of medication sticking out of the slot in the box. Inspector #522 was able to pull out medication from the medication box.

A Registered Nurse (RN) reviewed the medications in the storage box and stated that the box was full and the medication should not be accessible once they are put in the box.

Director of Care (DOC) stated that Pharmacy usually emptied the storage box of controlled substances for destruction monthly when completing the drug destruction.

During the inspection, Pharmacy Consultant and DOC completed drug destruction. DOC stated it looked like drug destruction had not been completed for several months, and the storage box on that floor was full as they had a higher level of medications that required destruction/disposal than other floors.

There was a risk to the security of the controlled substances as drug destruction had not occurred for several months and the storage box for controlled substances for drug destruction was overflowing and drugs were accessible.

Sources: Observations of an area of drug destruction, review of the home's "Management of Insulin, Narcotics and Controlled Substances" policy RC-16-01-13, last reviewed March 2023, and interviews with Registered Practical Nurse, RN, Pharmacy Consultant and DOC.
[522]

WRITTEN NOTIFICATION: Annual Evaluation

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (1)

Annual evaluation
s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure that the annual evaluation of the effectiveness of the medication management system in the home included the Administrator, the Medical Director and a registered dietitian who was a member of the staff of the home.

Rationale and Summary
Director of Care (DOC) stated the annual evaluation of the effectiveness of the medication management system was completed using the Institute for Safe Medication Practices Canada Medication Safety Self-Assessment for Long-Term Care. DOC stated this was completed with the Regional Director of Care and the Pharmacy Consultant in August, 2023, then discussed at the Professional Advisory Committee meeting in September.
DOC acknowledged that the Administrator, Medical Director, and Registered Dietitian were not a part of the annual evaluation.

Sources: Review of the Institute for Safe Medication Practices Canada Medication Safety Self-Assessment for Long-Term Care dated August 18, 2023, and interviews with DOC and the Administrator.
[522]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #017 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.

Rationale and Summary
Review of Quality Improvement Committee(QIC) meeting minutes for September 2023, noted that the committee was not composed of at least one Personal Support Worker (PSW).

Review of QIC meeting minutes for December 2023 noted that a PSW was a part of the CQI meeting, but was not in attendance.

In an interview, Administrator stated that they recruited a PSW to join the CQI committee prior to the meeting held in December 2023.

There was low risk to residents when the Quality Improvement Committee did not include at least one PSW.

Sources: Review of CQI meeting minutes for September and December 2023 and interview with Administrator.
[733564]