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: November 22, 2023	
Inspection Number: 2023-1222-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Kingsway Nursing Homes Limited	
Long Term Care Home and City: Kingsway Lodge Nursing Home, St Marys	
Lead Inspector Rhonda Kukoly (213)	**Inspector Digital Signature** Rhonda Kukoly Digitally signed by Rhonda Kukoly Date: 2023.11.22 16:33:08 -05'00'
Additional Inspector(s) Melanie Northey (563)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 1, 2, 3, 6, 7, 8, 9, 14, 2023

The following intake(s) were inspected:

- Intake: #00100315 - Proactive Compliance Inspection 2023

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

Skin and Wound Prevention and Management
Resident Care and Support Services
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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale & Summary
The IPAC Standard for Long-Term Care Homes stated: 9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: Point-of-care signage indicating that enhanced IPAC control measures are in place.

A resident had respiratory symptoms and was placed on isolation. There was an Airbourne Precaution sign indicating enhanced IPAC measures were in place to "keep door closed" and "wear N95, fit tested and seal-checked respirator" posted on the door to the resident's room. The appropriate use of PPE was not identified as a Droplet Contact Precaution, putting both residents and healthcare providers at risk of transmissible pathogens. Assistant Director of Care (ADOC) and DOC both verified there should have been a "Droplet Contact Precaution" sign posted on the door of the resident's room indicating the use of eye protection, gloves, a mask, and gown, and they immediately changed the sign.

Sources: Infection Prevention and Control Standard for Long-Term Care Homes, resident clinical record reviews, observations, and staff interviews. [563]
Date Remedy Implemented: November 9, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 148 (2) 2.

The licensee has failed to ensure that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that were available for administration to a resident, until the destruction and disposal occurs.

Rationale & Summary
In accordance with O. Reg 246/22 s.11 (1) b, the licensee was required to ensure the home's drug destruction policy was complied with. The policy stated all controlled substances which were to be destroyed should have been stored double locked in a secure, designated area within the home and separate from medications which were to be administered to residents.

Controlled drugs for destruction were observed in the controlled substance storage area with medications for administration. Staff said that they kept the medications there until the Director of Care (DOC) was available to destroy them. The DOC verified the controlled drugs for destruction were not stored in a double locked location away from the active medication supply until destruction, and the home was not in compliance with the Drug Destruction: Controlled Substances Policy 9.2.

The DOC immediately purchased and had a double locked stationary metal storage container bolted to the floor of the medication room, there was a slot and a small hole for registered staff to store controlled substances for drug destruction and the controlled substances were not accessible. The DOC and a registered staff member completed a count of controlled substances for destruction were counted and verified with no discrepancies.

Sources: Silver Fox Pharmacy Drug Destruction Policies, observations, and staff interviews. [563]
Date Remedy Implemented: November 9, 2023.

WRITTEN NOTIFICATION: Based on Assessment of Resident

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and on the needs and preferences of that resident.

Rationale & Summary
The care plan for a resident indicated they had impaired orientation and cognition, and impaired ability to communicate through speech or express feelings. Interviewing the resident and review of progress notes showed the resident's clear ability to express thoughts and feelings through clear speech and did not indicate impaired orientation or cognition. The Resident Assessment Instrument Coordinator could not explain why the resident's care plan and Minimum Data Set coding did not represent an accurate assessment of the resident's cognitive status or ability to communicate. There was risk that the resident might not have received the appropriate care or approach when their care plan was not based on an

accurate assessment of their needs.

Sources: Clinical record review, observations, resident interview and staff interviews. [563]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee has failed to seek the advice of the Residents' and Family Councils, in carrying out the resident and family/caregiver experience survey.

Rationale and Summary
The Administrator said that they used Abaqis to complete a resident and family satisfaction survey quarterly, they have used Abaqis for several years. Abaqis was a pre-set list of questions related to care including abuse, pain, food, nutrition, environment, skin, activities, privacy, dignity, dental, activities of daily living, accidents, bladder and bowel, and restraints. The Assistant Director of Care (ADOC) completed the survey by interviewing residents and mailing them out to families. The ADOC said that they did not seek advice from Residents' and Family Councils related to the format or questions asked in the satisfaction survey. Residents and families were not provided an opportunity to have input into carrying out the satisfaction survey, with this, it might not have captured relevant feedback or been effective.

Sources: Abaqis questionnaire results and staff interviews . [213]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (c)

The licensee has failed to ensure that the documented results of the resident and family/caregiver experience survey were made available to residents and their families.

Rationale and Summary
The documented results of the resident and family/caregiver experience survey provided by the Administrator included resident names and specific resident concerns. The results without resident

names or specific identifying concerns were not posted anywhere in the home or on the home's website. The Administrator said that they reviewed the results of the surveys during Residents' and Family Council meetings, but they were not posted and available to all residents and families in the home. Residents and families who did not attend Residents' or Family Councils meetings did not have documented survey results available to review to provide input or feedback.

Sources: Observations, review of the home's website and staff interview. [213]

WRITTEN NOTIFICATION: Only residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 62 (2)

The licensee has failed to ensure that only residents of the long-term care home were members of the Residents' Council.

Rationale and Summary
Residents' Council meeting minutes included multiple residents who resided in the retirement home as attendees of the meeting. The Director of Recreation, who acted as the Residents' Council assistant, said that they were not aware that only long-term care residents could be members of Residents' Council, and that they held the Residents' Council meetings together with both long-term care residents and retirement home residents. There was risk that long-term care residents' voices might not be heard when retirement residents were included in Residents' Council meetings.

Sources: Residents' Council meeting minutes, and staff interview. [213]

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)

The licensee has failed to ensure that when the Residents' Council advised the licensee of concerns, the licensee responded to the Residents' Council in writing within ten days of receiving the concern.

Rationale and Summary
A Kingsway Lodge and Residential Department Suggestions/Questions/Concerns form from a Residents' Council meeting, was signed by the president of the Residents' Council, who was a retirement home resident. The concerns form from another meeting had no responses included, it was not signed, and no date was filled in for date reported to council. The Director of Recreation said they provided the written

responses for the president to sign as received. Responses to that meeting were not available at the time of the inspection and had not yet been provided to the council, two weeks later. They said they reviewed the responses with the rest of the Residents' Council, including all of the long-term care resident members, at the following meeting, the next month, and they were not aware of the requirement to provide a written response to concerns to the Residents' Council within ten days. Residents who voiced a concern in Residents' Council Meetings did not have an opportunity to be made aware of or question responses to concerns until the following month.

Sources: The Kingsway Lodge and Residential Department Suggestions/Questions/Concerns form, from Residents' Council meetings, and staff interview. [213]

WRITTEN NOTIFICATION: Right to be a member

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (5)

The licensee has failed to ensure that family members or a persons of importance to long-term care home residents were members of the Family Council.

Rationale and Summary
The Family and Friends Council of Kingsway Lodge Concerns/Need Responses form from a Family Council meeting included concerns related to a resident on the first floor. The Director of Recreation, who acted as the Family Council assistant, said that residents on the first floor were retirement home residents, whereas, the second and third floor were long-term care residents. They said they were unaware that only long-term care residents' family and friends could be members of Family Council, and that they held the Family Council meetings together with both long-term care residents' and retirement home residents' family and friends. There was risk that long-term care residents' family's voices might not be heard when retirement residents' families were included in Family Council meetings.

Sources: Family and Friends Council of Kingsway Lodge Concerns/Need Responses form from a Family Council meeting, and staff interview. [213]

WRITTEN NOTIFICATION: Duty to respond

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)

The licensee has failed to ensure that when the Family Council advised the licensee of concerns, the licensee responded to the Family Council in writing within ten days of receiving the concern.

Rationale and Summary
The Family and Friends Council of Kingsway Lodge Concerns/Need Responses forms, from Family Council meetings, included concerns and responses. No dates were indicated for the date reported to council on either form. The Director of Recreation said they reviewed responses to concerns with the Family Council at the following meeting, the next month, and they were not aware of the requirement to provide a written response to concerns to the Family Council within ten days. Family members who voiced a concern in Family Council meetings did not have an opportunity to be made aware of, or question responses to concerns, until the following month.

Sources: The Family and Friends Council of Kingsway Lodge Concerns/Need Responses forms, from Family Council meetings, and staff interview. [213]

WRITTEN NOTIFICATION: Windows

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents, could not be opened more than 15 centimetres.

Rationale & Summary
A window in a resident room opened 73.66 centimetres. A staff member verified the window stopper was removed and the window opened fully past 15 centimetres. The window was fixed immediately, and the stopper was applied and tightened. The room was on the third floor and there were residents with cognitive impairment and those who wandered who had access to the window that opened greater than two feet.

Sources: Observations, resident and staff interview. [563]

WRITTEN NOTIFICATION: General requirements

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the required interdisciplinary programs, pain management, skin and wound care and falls prevention and management were evaluated and updated at least annually in accordance with evidence-based practices and, if none, in accordance with prevailing practices.

Rationale and Summary
The home's Administrator said that the required interdisciplinary programs including pain management, skin and wound care, and falls prevention and management were not evaluated annually. The home could not be aware of any deficiencies in the required programs, or updates that were necessary, when they didn't evaluate the programs.

Sources: Staff interview. [213]

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.

The licensee has failed to ensure that the dining and snack service that included all food and fluids being served at a temperature that were both safe and palatable to the residents.

Rationale and Summary
The food temperature logs one unit on two dates, did not include documentation of temperatures of soups at lunch or any hot cereals at breakfast. The Director of Dietary stated that temperatures of soups and hot cereals were taken in the production kitchen, but it was the responsibility of Personal Support Workers (PSW) on the unit to take the temperatures on the units before serving to residents. Dietary staff took temperatures of other foods before serving, but not the soups or hot cereals. The Director of Resident Care said that it was the dietary staff's responsibility to measure and document all food temperatures, they were not aware that PSWs were expected to take food temperatures and no one was monitoring to ensure they were being documented.

The most recent Abaqis survey completed in July 2023, included the following resident comments and feedback related to Food Services: Doesn't like any of the food, not served at the proper temperature, food does not look appetizing or taste good, and everything cold. Resolution indicated: Reported to Director of Dietary, encourage residents to ask staff to re-heat food.

The Food Preparation policy stated: Temperatures of all foods are taken with a calibrated thermometer and recorded before leaving the production area and, in the serveries at point of service, and recorded in the temperature binder. The policy didn't specify who was responsible to measure and document the temperatures. There was risk that the soups and hot cereals were not served at a temperature that was safe or palatable, when no one measured the temperatures between production and point of service.

Sources: The Food Preparation policy #04-4JJ, food temperature logs, Abaqis survey completed July 2023, and staff interviews. [213]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (e)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) program was evaluated and updated at least annually in accordance with the standards and protocols issued by the Director under subsection (2).

Rationale & Summary
The Administrator stated the home did not evaluate or update the IPAC program at least annually for 2022 or 2023. There was no written record that the IPAC program was evaluated and updated at least annually relating to any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance; and any standard or protocol issued by the Director with respect to IPAC. There was no evaluation, therefore no summary of the changes made or implemented to ensure the program was implemented in a manner consistent with the precautionary principle as set out in the standards and protocols issued by the Director and the most current medical evidence.

Source: Staff interview. [563]

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 (7) 2.

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead carried out the responsibility of managing and overseeing the infection prevention and control program in the home.

Rationale & Summary
The IPAC Lead stated their primary responsibility was to complete audits, that the IPAC program was a shared role with the Assistant Director of Care (ADOC), who performed some of the designated responsibilities of the IPAC lead. The IPAC Lead could not answer questions related to overseeing the delivery of infection prevention and control education, infectious disease surveillance, symptom monitoring, or daily and monthly screening results.

The ADOC verified they were the nursing clinical lead for the IPAC program and was managing and overseeing parts of the IPAC program. They verified the home was trying to sort out the responsibilities of the IPAC Lead since the ADOC had the responsibilities that were clinically based. The IPAC Lead was transitioning into that role to include the clinical based responsibilities currently managed by the ADOC.

The IPAC lead did not fulfill their legislative responsibilities in the designated position of managing and overseeing the IPAC program and the ADOC was not identified as a secondary IPAC Lead.

Sources: IPAC Lead Job Description, and staff interviews. [563]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead carried out the responsibility of overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents in the home.

Rationale & Summary
The IPAC Lead stated the online staff training program included the legislative IPAC training requirements for all new hires and for annual IPAC training. They stated they did not oversee the delivery of IPAC training, the Human Resources Coordinator was overseeing and managing staff education through the online program. The IPAC Lead could not provide information related to the delivery of IPAC education of visitors and residents. The IPAC lead did not fulfill their legislative responsibility in the designated position to oversee the delivery of IPAC education.

Sources: IPAC Lead Job Description, and staff interviews. [563]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 5.

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead carried out the responsibility of conducting regular infectious disease surveillance in the home.

Rationale & Summary
The Administration Department Job Description for the IPAC Lead documented a job summary that

stated, the IPAC Lead reported directly to the Administrator or Director of Resident Care and the IPAC Lead was a required role with responsibilities including daily surveillance.

The IPAC Lead stated the Assistant Director of Care (ADOC) was conducting regular infectious disease surveillance and the IPAC lead could not answer any questions related to surveillance. The ADOC stated they were conducting regular infectious disease surveillance by starting a line listing that was updated daily for residents in isolation and the information was provided to Public Health, that the nurses were monitoring and checking residents and documenting in the progress notes for symptoms indicating the presence of infection in residents. They stated the IPAC Lead was currently not responsible for conducting regular infectious disease surveillance in the home. The IPAC Lead did not fulfill their legislative responsibility in the designated position conducting regular infectious disease surveillance.

Sources: IPAC Lead Job Description, and staff interviews. [563]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 8.

The licensee has failed to ensure that the infection prevention and control (IPAC) lead designated carried out the responsibility of reviewing the documentation of residents presenting with signs and symptoms of infection.

Rationale & Summary
The IPAC Lead stated the Assistant Director of Care (ADOC) was responsible for reviewing screening results for residents presenting symptoms. The IPAC Lead could not provide any information related to the monitoring and information gathered related to symptoms indicating the presence of infection in residents or the immediate actions required as those decisions were made by the ADOC.

The ADOC stated they were monitoring and gathering information related to symptoms indicating the presence of infection in residents and the immediate actions required. The IPAC lead did not fulfill their legislative responsibilities in the designated position reviewing, monitoring and gathering information related to symptoms indicating the presence of infection in residents, the documentation of symptoms, and the immediate actions required.

Sources: IPAC Lead Job Description, and staff interviews. [563]

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 (7) 9.

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead carried out the responsibility of reviewing any daily and monthly screening results collected by the licensee to determine whether any action was required.

Rationale & Summary
The IPAC Lead stated the Assistant Director of Care (ADOC) was responsible for reviewing daily and monthly screening results for residents presenting symptoms and the ADOC was determining whether any action was required. The IPAC Lead could not provide any information related to the process for reviewing daily and monthly screening results or the decision process to determine whether any action was required.

The ADOC stated they were monitoring and gathering information related to the daily screening results related to symptoms indicating the presence of infection in residents and whether any action was required. The IPAC Lead did not fulfill their legislative responsibilities in the designated position reviewing any daily and monthly screening results collected by the licensee to determine whether any action was required.

Sources: IPAC Lead Job Description, and staff interviews. [563]

WRITTEN NOTIFICATION: Complaints procedure: licensee

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 107

The licensee has failed to ensure that the written procedures related to complaints, incorporated the requirements set out in the regulations.

Rationale and Summary
The home's Reporting Assessment & Resolving of Resident Concerns/Suggestions policy was a one page document that did not include all of the requirements of the regulations. The Administrator confirmed that the policy did not include all of the requirements and that the home did not follow all of the requirements of the regulations related to complaints.

Sources: Reporting Assessment & Resolving of Resident Concerns/Suggestions policy #CQIADM-0008, and staff interview. [213]

WRITTEN NOTIFICATION: Dealing with complaints

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (3) (a)

The licensee has failed to ensure that the documented record of complaints was reviewed and analyzed for trends at least quarterly.

Rationale and Summary
The administrator provided a file of ten documented complaints for the year. When asked if they reviewed and analyzed the complaints for trends and improvements needed, the Administrator said no. The home was not able determine if improvements were needed when complaints were not reviewed or analyzed for trends.

Sources: Complaints file and staff interview. [213]

WRITTEN NOTIFICATION: Annual Evaluation

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (1)

The licensee has failed to ensure that an interdisciplinary team met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale & Summary
An inspector requested a copy of the annual evaluation of the medication management system for 2022 or 2023, that included a review of the quarterly evaluations in the previous year. The Director of Care reached out to pharmacy by email to request the written document and verified an annual evaluation was not completed for 2022 or 2023.

Sources: Institute for Safe Medication Practices (ISMP) Canada Medication Safety Self-Assessment and staff interview. [563]

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 1.

The licensee has failed to ensure that drugs that were to be destroyed and disposed of, were stored safely and securely within the home.

Rationale & Summary
In accordance with O. Reg 246/22 s.11 (1) b, the licensee was required to ensure the home's non-controlled drug destruction policy was complied with. The Silver Fox Pharmacy Drug Destruction: Non-Controlled Substances Policy provided specific direction related to the denaturing and storage of medications for destruction that complied with the requirements of the regulations.

Non-controlled medications were observed in a container in a medication room in their original pharmacy packaging. Staff verified the medications were not emptied from their original pharmacy packaging, and the medications were not denatured. Once the containers were full, they were kept in an unlocked room in another area of the home. The DOC verified that storage area was not a secure designated area within the home accessible only to registered staff members. The DOC also verified this was not in compliance with their policy and stated the non-controlled drug destruction containers would be stored in a locked secured area accessible to registered staff only.

Sources: Drug Destruction Policies, observations and staff interviews. [563]

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (5) (a)

The licensee has failed to ensure that the drug destruction and disposal system was audited at least annually to verify that the licensee's procedures were being followed and were effective.

Rational & Summary
The medication inspection identified concerns related to the drug destruction and disposal controlled and non-controlled substances. The Director of Care (DOC) stated the home did not audit the drug destruction and disposal system annually to verify procedures were being followed and were effective. The DOC emailed Silver Fox Pharmacy and verified that an audit was not completed for 2022 or 2023.

Sources: DOC interview. [563]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included the home's medical director.

Rationale and Summary
The administrator provided the Kingsway Lodge Notice of CQI Committee meeting October 2023 It did not include the home's medical director. The Administrator said that the CQI committee did not include input from all of the required members including the home's medical director.

Sources: Kingsway Lodge Notice of CQI Committee meeting October 2023, and staff interview.[213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included the home's registered dietitian.

Rationale and Summary
The administrator provided the Kingsway Lodge Notice of CQI Committee meeting October 2023It did not include the home's registered dietitian. The Administrator said that the CQI committee did not include input from all of the required members including the home's registered dietitian.

Sources: Kingsway Lodge Notice of CQI Committee meeting October 2023, and staff interview. [213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included the home's pharmacy service provider, or a pharmacist from the pharmacy service provider.

Rationale and Summary
The administrator provided the Kingsway Lodge Notice of CQI Committee meeting October 2023. It did not include the home's pharmacy provider or a pharmacist. The Administrator said that the CQI committee did not include input from all of the required members including the home's pharmacy provider or pharmacist.

Sources: Kingsway Lodge Notice of CQI Committee meeting October 2023, and staff interview. [213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included at least one employee who was a member of the regular nursing staff of the home.

Rationale and Summary
The administrator provided the Kingsway Lodge Notice of CQI Committee meeting October 2023. It did not include a member of the regular nursing staff. The Administrator said that the CQI committee did not include input from all of the required members including a member of the regular nursing staff.

Sources: Kingsway Lodge Notice of CQI Committee meeting October 2023, and staff interview. [213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included at least one employee hired as a personal support worker or who provided personal support services at the home.

Rationale and Summary
The administrator provided the Kingsway Lodge Notice of CQI Committee meeting October 2023. It did not include a personal support worker. The Administrator said that the CQI committee did not include input from all of the required members including a personal support worker.

Sources: Kingsway Lodge Notice of CQI Committee meeting October 2023, and staff interview. [213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included one member of the home's Residents' Council.

Rationale and Summary
The administrator provided the Kingsway Lodge Notice of CQI Committee meeting October 2023. It indicated that the resident representative was a retirement home resident who was absent for that meeting. It did not include a member of the long-term care home's Resident's Council. The Administrator said that the CQI committee did not include input from all of the required members including a member of the home's Residents' Council member.

Sources: Kingsway Lodge Notice of CQI Committee meeting October 2023, and staff interview. [213]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included one member of the home's Family Council.

Rationale and Summary
The administrator provided the Kingsway Lodge Notice of CQI Committee meeting October 2023. It indicated that they were in the process of looking for a family representative. The Administrator said that the CQI committee did not include input from all of the required members, including one member of the home's Family Council.

Sources: Kingsway Lodge Notice of CQI Committee meeting October 2023, and staff interview. [213]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #031 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)

The licensee has failed to prepare a report on the continuous quality improvement initiative for the home for each fiscal year, no later than three months after the end of the fiscal year.

Rationale and Summary
There was no continuous quality improvement report posted on the home's website. The Administrator said that an annual continuous quality improvement report was not created in 2022 or 2023.

Sources: Kingsway Lodge public website and staff interview. [213]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #032 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.

The licensee has failed to prepare an interim continuous quality improvement report for the 2022-2023 fiscal year within three months of the coming into force of this section.

Rationale and Summary
There was no continuous quality improvement report posted on the home's website. The Administrator said that an interim continuous quality improvement report was not created in 2022.

Sources: Kingsway Lodge public website and staff interview. [213]