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 2, 2023	
Inspection Number: 2023-1151-0006	
Inspection Type: Proactive Compliance Inspection	
Licensee: Meadow Park (London) Inc.	
Long Term Care Home and City: Meadow Park (London), London	
Lead Inspector Meagan McGregor (721)	**Inspector Digital Signature** Meagan McGregor Digitally signed by Meagan McGregor Date: 2023.11.03 14:46:37 -04'00'
Additional Inspector(s) Melanie Northey (563)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 18-20, and 23-25, 2023

The following intake was inspected:

- Intake: #00099344 - Proactive Compliance Inspection 2023

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)
O. Reg. 246/22, s. 148 (2) 2.

The licensee failed to ensure that narcotic and controlled substances for drug destruction were securely stored in a double-locked stationary cupboard in the medication room prior to destruction.

Rationale & Summary

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the Long Term-Care (LTC) Narcotics and Controlled Substances Policy was complied with as a part of the Medication Management Program to ensure drugs that were to be destroyed and disposed were stored safely and securely within the home.

The home's LTC Narcotics and Controlled Substances Policy stated the "discontinued narcotic and controlled substances were to be placed in the double locked, permanently affixed cabinet within the medication room until the time of drug destruction by the pharmacist and Registered staff member."

Controlled substances for destruction were stored in a double locked stationary cupboard in the medication room, however the cupboard was overfilled and the drugs were accessible. When the Director of Care (DOC) and Co-DOC were present Inspector #563 easily removed several cards of controlled substances from the cupboard. The DOC verified the controlled drugs for destruction were not stored safely and securely within the home.

The Pharmacy Consultant arrived onsite and drug destruction was completed with the DOC and Co-DOC with no discrepancies.

Sources: Observations, review of the LTC Narcotics and Controlled Substances Policy, and staff interviews. [563]

Date Remedy Implemented: October 20, 2023

WRITTEN NOTIFICATION: Communication and Response System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal was coming from.

Rationale & Summary

The call bell system was randomly activated in resident rooms at the bedside and in the bathroom. A room in a specific resident home area was unoccupied at the time of the inspection, the call bell was activated and was easily cancelled at the point of activation in both the resident room and bathroom. However, there was no audio alert, and the room number electronically posted across a screen at the end of the hall and the message would not disappear when call bell was cancelled.

A Personal Support Worker (PSW) stated that there was usually a ringing as well to alert staff that a call bell had been activated. Another PSW stated that there was usually an audible alarm that could be heard in the hall, but the week prior all the call bells were alarming non-stop, and staff were told to keep peeking down the hall checking on call bells until it was fixed. This PSW stated the small ceiling mounted lights outside the residents' rooms were not used to indicate when a call bell had been activated, that the electronic screens at the ends of the hall were used to identify the room where the call had been activated.

A PSW notified the registered staff member that the call bell message would not disappear when call bell was cancelled in the bathroom of the identified resident room. The Environmental Service Manager (ESM) arrived and thought the malfunction of the call bell was in another resident's room on the same home area, not the identified resident room, as originally reported by Inspector #563. The ESM stated the electronic call bell message screens were at each end of the hallway and the notification of an activated call bell would disappear after five passes, that a service person from the call bell system provider was called and reset the system the day prior, and there seemed to be no concerns until that morning, when the electronic notification would not disappear after the pull station was cancelled at the point of activation. The resident room the ESM thought the malfunctioning call bell was in was checked multiple times and it was intermittent, the message for that call bell would disappear after a time without the call bell being reset. The call bell system provider was called, and they suggested to

replace the electronic screen at the end of the hall closest to the dining room. The ESM stated there was never an audio alarm in this home area before, however a couple of months ago, the call bell system provider made it audible because the electronic screens were not working consistently. The ESM verified the home areas call bell system was then constantly ringing without knowing which room it was coming from and disturbing residents, therefore the audible alert was disconnected by the call bell system provider because at that time the screens were functioning and additional pagers were ordered for the PSWs. The call bell system provider also turned off the message "room cleared" so that once the call bell was reset the message would disappear and only messages to answer a call bell would be displayed. The ESM stated the home area did not have an audio alarm at present, and there was a pager used by the registered nursing member on duty that indicated activation of the call bells in the home area and they would alert the PSWs.

The Administrator indicated that the home submitted a Critical Incident System (CIS) report related to a "Failure/breakdown of major system - Resident-staff communication and response system". The CIS report documented a previous call bell system failure that had occurred two and a half months prior, where the call bell system on this home area was not ringing. It was noted that five days prior to this current failure of the call bell system, a resident claimed they waited a very long time to receive care and that no one came to provide this care and the call bell was not working. At this time two managers tested the bed call bell and it worked and then tested the bathroom call bell and it showed two times then turned off. The ESM was notified and contacted the call bell system provider and it was fixed by the end of the day. The Administrator was then notified by staff the day after the current failure of the call bell system was identified that the call bell system was not working in the bathroom again, at which time the home contacted a security company to complete checks of the home area. The CIS report documented the ESM would be booking a visit with the call bell system provider to come to the home. Pagers for PSWs were implemented four days after the CIS report was submitted and five days after the malfunctioning call bell system was identified. The CIS documented "The system is working but has some glitches. Call bell system needs to be looked at more in depth to find out why it rings and then doesn't or if it displays a room two times and then disappears. Call has been made to [call bell system provider] to have technician out."

Staff response and the residents, staff and visitors' ability to communicate had been compromised when the call bell system did not consistently indicate when activated on the electronic message screen.

Sources: observations, policy review, audit reviews, CIS report, and staff interviews. [563]

WRITTEN NOTIFICATION: Oral Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

1.The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.

Rationale & Summary

A residents mouth appeared to have small amounts of food present. The resident stated they wore dentures. Although the resident stated PSWs remove their dentures and soak them overnight in a cleaning solution, their remaining teeth were not cleaned or brushed in the morning or evening. The resident stated they have a beverage before bed with no teeth brushing, and PSWs were not brushing their teeth every day in the morning. The resident stated their mouth was so dry in the morning, they were worried having their dentures put in for fear of impairing the integrity of their mouth. The resident stated there were no concerns with their mouth at that time.

The care plan for the resident documented they required assistance for oral care to brush teeth/gums and clean dentures. The resident stated they have difficulty performing mouth care independently. During a second observation of the resident, there was a noted white substance on their dentures and the resident stated staff did not provide mouth care to clean their teeth during morning care or last evening.

A PSW stated they provided mouth/oral care to the resident in the morning by providing the resident their dentures and stated an oral care swab was dipped in mouth wash to clean the resident's teeth. Inspector #563 and the PSW entered the bathroom for the resident and the PSW verified there were no oral care swabs or mouthwash available for use and the resident's denture brush was in a dirty food container located at the sink. The PSW then stated they could not recall if the resident received staff assistance for oral care to clean their teeth. There was also a basin in the residents' bathroom which had a toothbrush, small tube of toothpaste, a blue pen and a new container of dental floss sitting in dried toothpaste and what appeared to be saliva. The DOC verified the resident should have received oral care in the morning and evening and oral care supplies should be kept in a clean environment. The resident was at risk for bacteria and plaque buildup in their mouth, which could cause tooth decay and gum disease.

Sources: observations, resident interviews, clinical record reviews and staff interviews. [563]

2.The licensee failed to ensure that each resident of the home received oral care to maintain the

integrity of the oral tissue that included mouth care in the morning and evening.

Rationale & Summary

A resident stated they required support from staff with their oral care and they did not receive this care daily, in the morning and evening as required.

The care plan for the resident documented they required assistance for oral care.

The DOC and Resident and Family Service Coordinator (RFSC) verified their care plan identified staff were to provide assistance and the resident does not participate in the oral care routine. A PSW stated the resident did not have a toothbrush, was not offered a toothbrush, and was provided a cup of mouth wash and an oral care swab at times when requested.

The resident was not provided oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, putting the resident at risk for bacteria and plaque buildup in their mouth, which could cause tooth decay and gum disease.

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

WRITTEN NOTIFICATION: Oral Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (b)

1.The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included physical assistance or cuing to help a resident who cannot, for any reason, brush their own teeth.

Rationale & Summary

A residents mouth appeared to have small amounts of food present. The resident stated they wore dentures. Although the resident stated PSWs remove their dentures and soak them overnight in a cleaning solution, their lower teeth were not cleaned or brushed.

The care plan for the resident documented they required assistance for oral care to brush teeth/gums and clean dentures. The resident stated they have difficulty performing mouth care independently.

During a second observation of the resident, there was a noted white substance on their dentures and the resident stated staff did not provide the support required for mouth care to clean their teeth.

A PSW stated they provided mouth/oral care to the resident in the morning by providing the resident their dentures and stated an oral care swab was dipped in mouth wash to clean the resident's teeth. Inspector #563 and the PSW entered the bathroom for the resident and the PSW verified there were no oral care swabs or mouthwash available for use. The PSW then stated they could not recall if the resident received staff assistance for oral care to clean their teeth. The DOC verified the resident should have received the oral care assistance in the morning and evening that included physical assistance. The resident was at risk for bacteria and plaque buildup in their mouth, which could cause tooth decay and gum disease, when the planned extensive care to clean the resident's teeth was not provided.

Sources: observations, resident interviews, clinical record reviews and staff interviews. [563]

2.The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included physical assistance or cuing to help a resident who cannot, for any reason, brush their own teeth.

Rationale & Summary

A resident stated they required support from staff with their oral care and they did not receive this care daily as required.

The care plan for the resident documented they required assistance for oral care..

The DOC and RFSC verified their care plan identified staff were to provide assistance and the resident does not participate in the oral care routine. A PSW stated the resident did not have a toothbrush, was not offered a toothbrush, and was provided a cup of mouth wash and an oral care swab at times when requested.

The resident was not provided the physical assistance for oral care to maintain the integrity of the oral tissue, putting the resident at risk for bacteria and plaque buildup in the resident's mouth, which could cause tooth decay and gum disease.

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

WRITTEN NOTIFICATION: Continence Care and Bowel Management

Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

The licensee failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Rationale & Summary

In accordance with O. Reg 246/22 s. 11. (1) (b), the licensee was required to ensure the Long-Term Care (LTC) Continence Care and Bowel Management Program Policy was complied with. Specifically, registered staff did not comply with the licensee's Continence Care and Bowel Management Program Policy related to assessing continence on move in, annually or with a change in condition, which was part of the licensee's Continence and Bowel Management Program.

The LTC Continence Care and Bowel Management Program Policy documented each resident who was incontinent received an assessment for continence (urinary and bowel) under the Point Click Care (PCC) assessments that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. Each resident was to also receive a Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment under Section H for continence on admission, with significant change and quarterly. Each resident with bladder incontinence would then have a Resident Assessment Profile (RAP) completed that reflected critical thinking and evaluation of previous interventions and underlying causes of urinary incontinence.

The RAI MDS for a resident was completed quarterly since their admission to the home. The resident's control of urinary bladder function documented a fluctuation in their continence status since their admission to the home, however, it was documented on the quarterly assessments that had been completed since their admission to the home that they did not have a change in status for urinary continence and had "no change" in urinary bladder function.

The Co-DOC verified the Assessment of Incontinence V2 was the clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. They verified the Assessment for Continence should be completed on admission, annually and with any change in continence status, and

the resident who was incontinent had a change in continence status multiple times since their admission to the home and never received an assessment of incontinence annually.

An Assessment for Continence was completed for the resident when they were admitted to the home and their next assessment of incontinence was not completed until approximately six years later. The Co-DOC verified that with a change in the quarterly continence status it would be noted as part of the RAP, the RAI MDS assessor should have indicated that there was a deterioration or improvement, but not "no change" quarterly since their admission to the home. The Assessment for Continence had not been completed since the resident's admission to the home and should have been when there was an identified change in the resident's continence status with the quarterly completion of the RAI MDS. The resident was not assessed for the identification of causal factors, patterns, type of incontinence, putting the resident at risk when the potential to restore function with specific interventions was not identified.

Sources: review of the resident's clinical record, resident interview, staff interviews and review of LTC Continence Care and Bowel Management Program Policy. [563]

WRITTEN NOTIFICATION: Continence Care and Bowel Management Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

The licensee failed to ensure that a resident who required continence care products had sufficient changes to remain clean, dry and comfortable.

Rationale & Summary

A resident reported a staffing shortage on an identified shift on the home area where they resided. The resident stated they waited hours to have their wet continence care product changed, even after they requested assistance from two PSWs and the nurse on duty.

The Administrator and DOC verified that on the identified shift, the home was short by one PSW on the home area where the resident resided. The DOC stated the resident asked the Registered Practical Nurse (RPN) to be changed and the RPN forgot to tell PSW staff to change the resident's continence care product. The resident had a toileting plan that was not followed and was wet without the sufficient changes to remain clean, dry, and comfortable and putting the resident at risk for altered skin integrity.

Sources: clinical record review, policy review, and resident and staff interviews. [563]

WRITTEN NOTIFICATION: Menu planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

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

Rationale and Summary

During an observed lunch service, the weekly and daily menus posted in a dining room indicated that rice pudding was being offered as the alternate dessert item at this meal, however, there was no rice pudding observed to be offered and available at this meal.

The Food Service Supervisor (FSS) indicated that when a substitution was required on the planned menu, they would update the weekly and daily menus posted in the dining room to reflect this change. They said that jello was substituted for rice pudding at lunch on this date due to a delay in receiving their milk shipment and they forgot to update the weekly and daily menus to reflect this change.

Sources: observations of meal service and posted menus; and staff interviews.[721]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 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 and Summary

The IPAC Standard for LTC Homes stated the following:
9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
d) Proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

e) Point-of-care signage indicating that enhanced IPAC control measures are in place.

A resident was identified with exposure to a respiratory illness. There was no precaution signage posted at the entrance to the residents' room or bed space indicating enhanced IPAC measures were in place. There was no PPE cart beside the resident's door, no donning/doffing signage, and no PPE disposal receptacle available. A PSW verified there were no enhanced IPAC measures in place and the resident was isolated due to recent possible exposure to a respiratory illness. A PSW stated the resident should have a sign and all PPE available and they did not. The IPAC Lead stated a precaution sign was not in place for this resident with respiratory illness exposure. The resident had already received morning care at the time of the observation and staff did not implement the proper appropriate use of PPE before providing care.

Another resident was identified as having a bacterial infection. There was no precaution signage posted at the entrance to the resident's room or bed space indicating enhanced IPAC measures were in place. There was an empty PPE cart beside the resident's door. A PSW was providing the snack cart at that time and stated the resident had a bacterial infection and verified a sign was not posted and the PPE cart was empty. The IPAC Lead verified that there should have been a precaution sign in place and the appropriate PPE available for the resident with the bacterial infection.

It was the responsibility of all staff to keep residents healthy and prevent the spread of respiratory and bacterial infections. Infection can spread from person to person or from surfaces to people. PPE protects healthcare workers from virulent pathogens by preventing exposure to bodily fluids and respiratory droplets. The appropriate use of PPE was not implemented putting residents at risk, and those strategies have been effective interventions for protecting both residents and healthcare providers from transmissible pathogens when in use.

Sources: IPAC Standard for LTC Homes, resident clinical record reviews, observations and staff interviews. [563]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #011 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 was composed of at least one employee of the licensee who had been hired as a PSW.

Rationale and Summary

Minutes from home's Quality Council meetings held over the past year did not show any documented record of a PSW participating in the home's CQI initiatives or being invited to attend these meetings.

The Administrator confirmed that the CQI committee in the home did not include any designated PSW staff in the home as part of its membership.

Sources: review of the home's Quality Council meeting minutes; and staff interviews. [721]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 3.

The licensee has failed to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written description of the process used to identify the home’s priority areas for quality improvement for the next fiscal year and how the home’s priority areas for quality improvement for the next fiscal year were based on the recommendations of the home’s CQI committee.

Rationale and Summary

A copy of the home's CQI initiative report for the previous fiscal year was reviewed on the home's website and on the quality improvement board in the home. This report did not include a written description of the process used to identify the home’s priority areas for quality improvement for the next fiscal year and how the home’s priority areas for quality improvement for the next fiscal year were based on the recommendations of the home’s CQI committee.

The Administrator, who was the designated lead for the CQI initiative in the home, confirmed the home's CQI initiative report which was posted on the website and on the quality improvement board did not contain a written description of this information within the report.

Sources: review of the home's "Final Quality Report for 2022"; and staff interviews. [721]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 4.

The licensee has failed to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written description of the process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

Rationale and Summary

A copy of the home's CQI initiative report for the previous fiscal year was reviewed on the home's website and on the quality improvement board in the home. This report did not include a written description of the process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

The Administrator, who was the designated lead for the CQI initiative in the home, confirmed the home's CQI initiative report which was posted on the website and on the quality improvement board did not contain a written description of this information within the report.

Sources: review of the home's "Final Quality Report for 2022"; and staff interviews. [721]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. i.

The licensee has failed to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written record of the date the Resident and Family/Caregiver Experience Survey was taken during the fiscal year.

Rationale and Summary

FLTCA s.43 required the home to ensure that, unless otherwise directed by the Minister, at least once in every year a survey was taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

A copy of the home's CQI initiative report for the previous fiscal year was reviewed on the home's website and on the quality improvement board in the home. This report did not include a written record

of the date the Resident and Family/Caregiver Experience Survey was taken during the fiscal year.

The Administrator, who was the designated lead for the CQI initiative in the home, confirmed the home's CQI initiative report which was posted on the website and on the quality improvement board did not contain a written record of this information within the report.

Sources: review of the home's "Final Quality Report for 2022"; and staff interviews. [721]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. ii.

The licensee has failed to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written record of the results of the Resident and Family/Caregiver Experience Survey taken during the fiscal year.

Rationale and Summary

A copy of the home's CQI initiative report for the previous fiscal year was reviewed on the home's website and on the quality improvement board in the home. This report did not include a written record of the results of the Resident and Family/Caregiver Experience Survey taken during the fiscal year.

The Administrator, who was the designated lead for the CQI initiative in the home, confirmed the home's CQI initiative report which was posted on the website and on the quality improvement board did not contain a written record of this information within the report.

Sources: review of the home's "Final Quality Report for 2022”; and staff interviews. [721]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.

The licensee has failed to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written record of how, and the dates when, the results of the Resident and Family/Caregiver Experience Survey taken during the fiscal year were communicated to the residents and their families,

Residents' Council, and members of the staff of the home.

Rationale and Summary

A copy of the home's CQI initiative report for the previous fiscal year was reviewed on the home's website and on the quality improvement board in the home. This report did not include a written record of how, and the dates when, the results of the Resident and Family/Caregiver Experience Survey taken during the fiscal year were communicated to the residents and their families, Residents' Council, and members of the staff of the home.

The Administrator, who was the designated lead for the CQI initiative in the home, confirmed the home's CQI initiative report which was posted on the website and on the quality improvement board did not contain a written record of this information within the report.

Sources: review of the home's "Final Quality Report for 2022"; and staff interviews. [721]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iii.

The licensee has failed to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written record of the role of the Residents' Council in acting to improve the long-term care home, and the care, services, programs and goods during the fiscal year.

Rationale and Summary

O. Reg. 246/22 s.168 (2) 6. i. required the home to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written record of the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the Resident and Family/Caregiver Experience Survey taken during the fiscal year, the dates the actions were implemented and the outcomes of the actions.

O. Reg. 246/22 s.168 (2) 6. ii. required the home to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written record of any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the

outcomes of the actions.

A copy of the home's CQI initiative report for the previous fiscal year was reviewed on the home's website and on the quality improvement board in the home. This report did not include a written record of the role of the Residents' Council in acting to improve the long-term care home, and the care, services, programs and goods during the fiscal year.

The Administrator, who was the designated lead for the CQI initiative in the home, confirmed the home's CQI initiative report which was posted on the website and on the quality improvement board did not contain a written record of this information within the report.

Sources: review of the home's "Final Quality Report for 2022"; and staff interviews. [721]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iv.

The licensee has failed to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written record of the role of the CQI committee in acting to improve the long-term care home, and the care, services, programs and goods during the fiscal year.

Rationale and Summary

A copy of the home's CQI initiative report for the previous fiscal year was reviewed on the home's website and on the quality improvement board in the home. This report did not include a written record of the role of the CQI committee in acting to improve the long-term care home, and the care, services, programs and goods during the fiscal year.

The Administrator, who was the designated lead for the CQI initiative in the home, confirmed the home's CQI initiative report which was posted on the website and on the quality improvement board did not contain a written record of this information within the report.

Sources: review of the home's "Final Quality Report for 2022"; and staff interviews. [721]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.

The licensee has failed to ensure that the home's report on the CQI initiative for the previous fiscal year contained a written record of how and the dates when actions taken to improve the long-term care home, and the care, services, programs and goods during the fiscal year, the dates the actions were implemented and the outcomes of the actions, were communicated to residents and their families, the Residents' Council, and members of the staff of the home.

Rationale and Summary

A copy of the home's CQI initiative report for the previous fiscal year was reviewed on the home's website and on the quality improvement board in the home. This report did not include a written record of how and the dates when actions taken to improve the long-term care home, and the care, services, programs and goods during the fiscal year, the dates the actions were implemented and the outcomes of the actions, were communicated to residents and their families, the Residents' Council, and members of the staff of the home.

The Administrator, who was the designated lead for the CQI initiative in the home, confirmed the home's CQI initiative report which was posted on the website and on the quality improvement board did not contain a written record of this information within the report.

Sources: review of the home's "Final Quality Report for 2022"; and staff interviews. [721]