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: January 18, 2024

Inspection Number: 2023-1443-0005

Inspection Type:
Proactive Compliance Inspection

Licensee: Benevolent Society "Heidehof" for the Care of the Aged

Long Term Care Home and City: Heidehof Long Term Care Home, St Catherines

Lead Inspector	**Inspector Digital Signature**
Jonathan Conti (740882)	Jonathan Conti Digitally signed by Jonathan Conti Date: 2024.02.01 10:03:17 -05'00'

Additional Inspector(s)
Nishy Francis (740873)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4-5, 8-12, 2024.

The following intake(s) were inspected:

- Intake #00105102 for Proactive Compliance Inspection.

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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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.

The licensee failed to ensure that a resident's plan of care was revised when the resident's care needs changed for level of assistance required for eating.

Rationale and Summary
As of a specified date, the Registered Dietitian (RD) updated a resident's plan of care to include that the resident required a certain level of feeding assistance.

On a date in January 2024, a resident was observed during lunch meal service. During observation, it was noted that staff did not provide the required level feeding assistance for the resident as care planned, and instead provided a lower level of assistance throughout the meal as the resident was able to feed themselves.

Documentation from Personal Support Workers (PSWs) regarding level of assistance needs for the month of January 2024 indicated the resident only received supervision to limited assistance with eating. Interviews with staff confirmed that the resident was able to self-feed with minimal staff assistance and supervision. Staff stated that the current plan of care for the resident regarding level of assistance needed was no longer necessary.

The Minimum Data Set Resident Assessment Instrument (MDS-RAI) Coordinator reviewed with staff the revised eating assistance needs for resident on a later date in January 2024, and the plan of care for resident was revised accordingly. The MDS-RAI Coordinator acknowledged that resident's care planned need for a certain level of eating assistance was no longer necessary and revised the plan of care after assessment.

Sources: Interviews with MDS-RAI Coordinator and other staff; observation of resident; plan of care for resident. [740882]

Date Remedy Implemented: January 5, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 65 (7) (a)
Family Council
Licensee obligations if no Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and

The licensee failed to ensure the obligation of when the home has no Family Council, that on an ongoing basis there was advisement to residents' families and persons of importance to residents of the right to establish a Family Council.

Rationale and Summary
On the morning of January 10, 2024, observation of the whole home and communication boards for residents and families indicated there was no advisement for right to establish a Family Council. Memos sent out to families in 2023 were reviewed and no indication that this right was advised on.

The Director of Care (DOC) confirmed that there was no posting or communication in the last year regarding Family Council rights to establish in the home. Follow up with the Executive Director (ED) confirmed there was no ongoing advisement of the above.

On the afternoon of January 10, 2024, observation of the North End entrance communication board was made and there was a posted sign for families to contact the ED regarding the right to form a Family Council.

Sources: Observations of communication boards; 2023 memos to families;

interviews with DOC and ED. [740882]

Date Remedy Implemented: January 10, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
Required information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was posted as per mandatory postings in the home.

Rationale and Summary
During the tour of the home on January 10, 2024, Inspector #740873 observed that the policy to promote zero tolerance of abuse and neglect was not posted in an easily accessible location as per requirements. The Director of Care confirmed that the policy was not posted.

On January 10, 2024, Director of Care advised the inspector that the policy to promote zero tolerance of abuse and neglect of residents was now on the front entrance board. Inspector conducted observations which confirmed the policy to promote zero tolerance of abuse and neglect was posted in an easily accessible location as per requirements.

Sources: Required information posted at the entrance of the home, policies provided by the home; interview with the Director of Care. [740873]

Date Remedy Implemented: January 10, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
Required information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee has failed to ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act included an explanation of the whistle-blowing protection.

Rationale and Summary
During the tour of the home on January 10, 2024, Inspector #740873 observed that the explanation of the whistle-blowing protection was not posted in an easily accessible location as per requirements. The Director of Care confirmed that the explanation was not posted.

On January 10, 2024, the Director of Care advised the inspector that the explanation of the whistle-blowing protection consistent with the requirements under the FLTCA was now on the front entrance board. Inspector conducted observations which confirmed the explanation of the whistle-blowing protection was posted in an easily accessible location as per requirements.

Sources: Observation of the home for mandatory postings; Interview with the DOC. [740873]

Date Remedy Implemented: January 10, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
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:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure that the dining, and snack services had the required communication of the seven-day menu to residents.

Rationale and Summary
During meal observation January 4, 2024, it was identified that there were no postings of the seven-day menu on the third-floor home area. A walkthrough of the first and second floor home areas indicated that the seven-day menu was not communicated to residents.

The Dietary and Environmental Services Manager and other staff confirmed that seven-day menu was not posted on the floors. Staff indicated that the electronic screens for display of the menus was not functioning correctly, and that the seven-day menus were not communicated to residents' during the observation date.

On January 8, 2024, it was observed that the seven-day menu was posted on all floors for the current menu cycle.

Sources: Observations of dining areas; interview with staff #103, #104; current menu cycles seven-day menu. [740882]

Date Remedy Implemented: January 8, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home and communicated to residents under section 5 of the Act as required.

Rationale and Summary
During the tour of the home on January 10, 2024, Inspector #740873 observed that the current version of the visitor policy was not posted in the home and communicated to residents as per requirements. The Director of Care confirmed that the policy was not posted.

On January 10, 2024, the Director of Care advised the inspector that the current version of the visitor policy was now posted and available in the front entrance. Inspector conducted observation which confirmed the current version of the visitor policy was posted in the home as per requirements.

Sources: Observation of the home for mandatory postings; Interview with the DOC.

[740873]
Date Remedy Implemented: January 10, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that a specified item was not served to a resident as specified in their plan of care.

Rationale and Summary
A resident had an specified intervention due to their medical diagnosis and family request. This intervention was communicated to staff through the resident's plan of care and posted for dietary staff on the unit kitchen board.

During lunch service on a specified date, the resident was noted to be served an item that was not to be provided as outlined in their plan of care. Staff acknowledged that the resident should not of been served the specified item as it was in their care plan for it not to be provided.

By the resident receiving a specific item at meal service, the resident was at potential risk for complications based on their medical diagnosis.

Sources: Observations January 2024; resident clinical records including care plan

and progress notes; interview with staff. [740882]

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
When reassessment, revision is required
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.

The licensee has failed to ensure that when resident was reassessed and the plan of care reviewed as the resident's care needs changed, that the plan of care was revised.

Rationale and Summary
Observations and interview with staff stated that a resident utilized a specific device for all transfers. The plan of care indicated the resident used a different device for transfers. The physiotherapist stated the resident was assessed on a specified date as safe to use a specific device for transfers. The physiotherapist confirmed the plan of care was not revised when the resident was re-assessed.

On a later date the care plan was updated by the RAI-MDS coordinator to state the resident required two-person transfer. The RAI-MDS coordinator acknowledged the care plan did not reflect the assessment from the physiotherapist.

Sources: Interviews with Physiotherapist and other staff; review of resident clinical record. [740873]

WRITTEN NOTIFICATION: Family Council

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
Licensee obligations if no Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee failed to ensure the obligation when the home has no Family Council, that they convened semi-annual meetings in 2023 to advise the residents' families and persons of importance to residents of the right to establish a Family Council.

Rationale and Summary
Observations of the home's communication boards and review of the home's communication memos to families indicated that no semi-annual meetings were held in 2023 to advise of the right to form a Family Council.

The Executive Director (ED) confirmed that there was no communication or convening of semi-annual meetings for the year 2023 that would of advised families of the right to establish a Family Council in the home.

There was potential risk that families and persons of importance to the residents of the home may not have been aware of the right to establish a Family Council.

Sources: Family communication memos for 2023; observations; interview with DOC and ED. [740882]

WRITTEN NOTIFICATION: Retraining

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

Non-compliance with: FLTCA, 2021, s. 82 (4)

Training

Retraining

s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that the persons who received training under subsection (2) received the retraining in the areas mentioned in that section at the intervals as provided for in the regulations.

Rationale and Summary

FLTCA s. 82 (1) identified that all staff in the home were to receive training in the areas as required.

FLTCA s. 82 (2) identified that training was required in the areas, including: the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to make mandatory reports.

O. Reg. 246/22 s. 260 (1) identified the retraining was to be completed at annual intervals.

The home provided course completion training records for 2023 for staff training for the prevention of Abuse and Neglect. Records identified that in 2023 only 43 per cent of the staff completed the required training.

There was a risk that not all staff were familiar with the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 28 to

make mandatory reports, when they did not receive annual retraining as required.

Sources: Review of staff training records and interview with the Nurse Educator and Director of Care. [740873]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee failed to ensure that records of the annual evaluation of the required pain management program were kept including the dates evaluations were conducted, the names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented.

Rationale and Summary
The Pain Management program under O. Reg. 246/22, s. 53 (1) 4, indicates it is a required program for the long-term care home. As such, the required program requires annual evaluation and for a written record of each evaluation to be kept.

Review of the homes' Pain Management program and policies indicated a last reviewed date of July 2023. The homes Director of Care (DOC) and Executive Director (ED) were unable to provide a written record that outlines the requirements of this legislation. The ED stated that the home did not have a formal annual evaluation record that outlined the who participated in the evaluation or of any changes made to the program.

By the home not maintaining a written record of the Pain Management program evaluation, it could not be verified that the required program had an interdisciplinary review, and thus could impact the pain management interventions provided to residents at the home.

Sources: Failure of licensee to provide a record of evaluation of the Pain Management program; interview with Executive Director and Director of Care. [740882]

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 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that the Residents' Council was provided with a copy of the continuous quality improvement (CQI) initiative report for the fiscal year of 2022-2023.

Rationale and Summary
A review of the 2023 Residents' Council (RC) meeting minutes was conducted, and there was no confirmation that a copy of the CQI report was provided to the residents of the home. There was no posting of the report in the home for resident or family review.

Interview with a RC representative indicated they were not made aware of CQI report results, nor provided with a copy in 2023 at a RC meeting. The Life Enrichment Manager (LEM) and the Executive Director (ED) acknowledged that a copy was not provided to the Residents' Council, and only the feedback from the 2023 Resident and Family Feedback Survey was reviewed.

By the home failing to provide the RC with a copy of the most recent CQI report, there was potential for the residents not being informed on the homes' identified areas of improvement.

Sources: Interview with resident #004, LEM, and ED; meeting minutes for RC 2023. [740882]

WRITTEN NOTIFICATION: Orientation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (b)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(b) modes of infection transmission;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to modes of infection transmission.

Rationale and Summary
A review of the IPAC education provided to all staff prior to working in the home did not include modes of infection transmission as required under the required areas of Infection Prevention and Control. The IPAC Lead and Nurse Educator confirmed the IPAC education did not include modes of infection transmission.

When modes of infection transmission were not included in the required IPAC education provided to all staff members, residents were placed at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: Review of Hand Hygiene educational training and Donning and Doffing educational training on Surge Learning System; interviews with IPAC lead, Nurse Educator, and the DOC. [740873]

WRITTEN NOTIFICATION: Orientation

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The licensee has failed to ensure that training was provided to all staff working in

the home under the required areas of Infection Prevention and Control, specific to signs and symptoms of infectious diseases.

Rationale and Summary
A review of the IPAC education provided to all staff prior to working in the home did not include signs and symptoms of infectious diseases as required under the required areas of Infection Prevention and Control. The IPAC Lead and Nurse Educator confirmed the IPAC education did not include signs and symptoms of infectious diseases.

When signs and symptoms of infectious diseases were not included in the required IPAC education provided to all staff members, residents were placed at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: Review of Hand Hygiene educational training and Donning and Doffing educational training on Surge Learning System; interviews with IPAC lead, Nurse Educator, and the DOC. [740873]

WRITTEN NOTIFICATION: Orientation

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The licensee has failed to ensure that training was provided to all staff working in

the home under the required areas of Infection Prevention and Control, specific to respiratory etiquette.

Rationale and Summary
A review of the IPAC education provided to all staff prior to working in the home did not include respiratory etiquette as required under the required areas of Infection Prevention and Control. The IPAC Lead and Nurse Educator confirmed the IPAC education did not include respiratory etiquette training.

When respiratory etiquette was not included in the required IPAC education provided to all staff members, residents were placed at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: Review of Hand Hygiene educational training and Donning and Doffing educational training on Surge Learning System; interviews with IPAC lead, Nurse Educator, and the DOC. [740873]

WRITTEN NOTIFICATION: Orientation

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to what to do if experiencing symptoms of infectious disease.

Rationale and Summary
A review of the IPAC education provided to all staff prior to working in the home did not include what to do if experiencing symptoms of infectious disease as required under the required areas of Infection Prevention and Control. The IPAC Lead and Nurse Educator confirmed the IPAC education did not include what to do if experiencing symptoms of infectious disease.

When actions to take if experiencing symptoms of infectious disease was not included in the required IPAC education provided to all staff members, residents were placed at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: Review of Hand Hygiene educational training and Donning and Doffing educational training on Surge Learning System; interviews with IPAC lead, Nurse Educator, and the DOC. [740873]

WRITTEN NOTIFICATION: Orientation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (f)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(f) cleaning and disinfection practices;

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to cleaning and disinfection practices.

Rationale and Summary
A review of the IPAC education provided to all staff prior to working in the home did not include cleaning and disinfection practices as required under the required areas of Infection Prevention and Control. The IPAC Lead and Nurse Educator confirmed the IPAC education did not include cleaning and disinfection practices.

When cleaning and disinfection practices was not included in the required IPAC education provided to all staff members, residents were placed at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: Review of Hand Hygiene educational training and Donning and Doffing educational training on Surge Learning System; interviews with IPAC lead, Nurse Educator, and the DOC. [740873]

WRITTEN NOTIFICATION: Orientation

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that training was provided to all staff working in the home under the required areas of Infection Prevention and Control, specific to

handling and disposing of biological and clinical waste including used personal protective equipment.

Rationale and Summary
A review of the IPAC education provided to all staff prior to working in the home did not include handling and disposing of biological and clinical waste including used personal protective equipment as required under the required areas of Infection Prevention and Control. The IPAC Lead and Nurse Educator confirmed the IPAC education did not include handling and disposing of biological and clinical waste including used personal protective equipment.

When handling and disposing of biological and clinical waste including used personal protective equipment was not included in the required IPAC education provided to all staff members, residents were placed at increased risk of infection transmission due to the possibility of the education not being provided in full, as required.

Sources: Review of Hand Hygiene educational training and Donning and Doffing educational training on Surge Learning System; interviews with IPAC lead, Nurse Educator, and the DOC. [740873]

WRITTEN NOTIFICATION: Additional training- direct care staff

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.

The licensee has failed to ensure that all staff who provide direct care to residents receive training on the required program for fall prevention and management in 2023.

Rationale and Summary
A review of the home's training records for all direct care staff on fall prevention and management identified that the completion rate for 2023 was 46.3 per cent.

The Nurse Educator (NE) identified there was a training gap in 2023, and that the expectation was for 100 per cent of direct care staff to complete the annual training. The NE confirmed that this expectation was not met as indicated by the provided training records for the identified fall prevention and management courses.

There was a potential risk that all direct care staff may not be familiar with the home's fall prevention and management program when they did not receive annual training as required.

Sources: Training records required completion report for 2023; interview with Nurse Educator. [740882]

WRITTEN NOTIFICATION: Additional training- direct care staff

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

2. Skin and wound care.

The licensee has failed to ensure that all staff who provide direct care to residents receive training on the required program for skin and wound care in 2023.

Rationale and Summary
A review of the home's training records for all direct care staff on skin and wound care identified that the completion rate for 2023 was 46.3 per cent.

The Nurse Educator (NE) identified there was a training gap in 2023, and that the expectation was for 100 per cent of direct care staff to complete the annual training. The NE confirmed that this expectation was not met as indicated by the provided training records.

There was a potential risk that all direct care staff may not be familiar with the home's skin and wound care program when they did not receive annual training as required.

Sources: Training records required completion report for 2023; interview with Nurse Educator. [740882]

WRITTEN NOTIFICATION: Additional training- direct care staff

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of

pain.

The licensee has failed to ensure that all staff who provide direct care to residents receive training on the required program for pain management in 2023.

Rationale and Summary
A review of the home's training records for all direct care staff on pain management identified that the completion rate for 2023 was 45.5 per cent.

The Nurse Educator (NE) identified there was a training gap in 2023, and that the expectation was for 100 per cent of direct care staff to complete the annual training. The NE confirmed that this expectation was not met as indicated by the provided training records.

There was a potential risk that all direct care staff may not be familiar with the home's pain management program when they did not receive annual training as required.

Sources: Training records required completion report for 2023; interview with Nurse Educator. [740882]