Lifecare Funds Limited - Kolmar Lodge Rest Home

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Lifecare Funds Limited
Premises audited:	Kolmar Lodge Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 October 2020 End date: 8 October 2020

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 22

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Kolmar Lodge Rest Home is one of three facilities owned by Lifecare Funds Limited. The facility provides rest home care for up to 26 residents. On the day of the audit there were 22 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, the GP, and management.

The operations manager (registered nurse) has considerable experience in aged care and is supported by a clinical coordinator (registered nurse) who also has experience in aged care. They are supported by long-standing staff.

The service has met all the standards included as part of this audit.

A rating of continuous improvement has been awarded for the work completed around infection control surveillance during the pandemic. The operations manager and staff have continued to build on the continuous improvement awarded in the same area in the last certification audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open. Residents and relatives interviewed were very complimentary of the services and care they or their family member receives.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. A register of complaints is kept.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Operational and clinical management and leadership is provided by the operations manager.

There is a documented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the operations manager and/or clinical coordinator. All aspects of the quality programme are discussed meetings. The health and safety programme is implemented.

Human resource policies are documented. An orientation programme is in place for new staff. An annual staff education and training plan is documented and implemented. There is always a registered nurse on duty (operations manager or clinical coordinator) during the day with both taking turns at being on call.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

The operations manager or clinical coordinator are responsible for each stage of service provision. This includes assessment and care planning with the resident and family/whānau input if possible. Care plans demonstrated service integration and resident/relative input into care.

The operations manager is a diversional therapist, and they oversee the activities programme. Caregivers are rostered as activities coordinators and they implement the documented programme. All caregivers engage in activities with residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and preferences for each resident group. Residents and relatives reported satisfaction with the activities programme.

Medication policies reflect legislative requirements and guidelines. The operations manager, clinical coordinator or caregivers are responsible for the administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three-monthly.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is equipped to meet food service requirements. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The building has a current building warrant of fitness in place. Reactive and preventative maintenance schedules are in place and maintained. Outdoor areas are well maintained and easily accessible to all residents using mobility aids.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Staff regularly receive training around restraint minimisation and the management of challenging behaviour. There were no restraints or enablers used in the service.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There have not been any outbreaks since the previous audit. The service has continued to implement a comprehensive surveillance programme.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	1	40	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed (the operations manager, assistant manager/relief cook, registered nurse, four caregivers including two who were also interviewed in their role as activities coordinators, and the maintenance person) were able to describe the process around reporting complaints. There is a complaint register that includes complaints received, dates and actions taken as per the complaints. The operations manager stated that they would sign off each complaint when it is closed. There is evidence of complaints being discussed in the staff meetings. There have not been any complaints in the past four years. Residents and family interviewed confirmed that they were very satisfied with the service and had not had any complaints. There are no complaints from external providers since the last audit.
Standard 1.1.9: Communication Service providers communicate	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 15 incidents reviewed (September and October 2020) indicated that family are kept informed.

effectively with consumers and provide an environment conducive to effective communication.		Quarterly family/resident meetings provide a venue where issues can be addressed. Seven residents interviewed stated that there was good communication with staff and managers, and they felt informed of changes in the organisation. An interpreter service is available and accessible if required. Families and staff are utilised in the first instance. Documentation of contact and communication with family in the care plan shows that all family are contacted at least three monthly or at intervals determined by the family. The amount of communication has increased during the pandemic with the operations manager keeping family informed at regular intervals. Two family interviewed congratulated the operations manager on the way in which they were kept informed of any incidents, changes in a resident's condition and around Covid-19. A message board in the facility has been set up to provide more detailed information around Covid-19.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Kolmar Lodge Rest Home provides care for up to 26 residents with 22 rest home beds occupied on the day of audit. This is one of three aged care facilities owned and managed by Lifecare Funds Limited. The service is certified to provide rest home level of care. All residents are under the Age-Related Care contract apart from one under a long-term service – chronic care contract (LTS-CHC) and one using respite services. A 2019 to 2021 business plan is documented. The plan links to objectives documented in the long-term business development plan March 2020 to March 2025. The plans are reviewed through the integrated management meeting attended by the directors, operations manager, and the clinical coordinator. The vision (to provide a homely environment) and values are documented and displayed in the foyer. The operations manager and clinical coordinator confirmed knowledge of the vision and values and were able to give examples of how these were implemented. The operations manager is a registered nurse with a current annual practicing certificate who has been in the role for over 15 years. She is supported by a clinical coordinator (registered nurse) who has been in the role for two years and has another 18 months experience in aged care.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and	FA	An established quality and risk management system is documented. Quality and risk performance is reported through staff and integrated management meetings held with evaluation of the plan against goals completed monthly. Discussions with the operations manager, clinical coordinator and staff showed staff involvement in quality and risk management processes. Resident and family meetings are held quarterly. Minutes are maintained. Annual resident satisfaction surveys were last completed in 2019 and 2020 with these showing a high level of satisfaction. No issues or opportunities for improvement were identified.

maintained quality and risk management system that reflects continuous quality improvement principles.		The service has policies and procedures and associated implementation systems, and these adhere to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed on a two-yearly schedule or as changes occur, and these are current. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff in meetings or through day-to-day conversations and as part of the handover process as observed during the day. Corrective action plans are implemented when opportunities for improvements are identified (e.g., internal audit results). Corrective actions are signed off when completed. Health and safety policies are implemented and monitored through the staff meeting. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Falls prevention strategies are in place including post-falls assessments.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by the operations manager when completed. A review of 15 accident/incident forms showed forms were fully completed and include follow-up by the operations manager. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are recorded and completed for any suspected injury to the head or for an unwitnessed fall as per policy. The operations manager and clinical coordinator were able to identify situations that would be reported to statutory authorities including infectious diseases, serious accidents, and unexpected death. There has not been a need to lodge a section 31 report since the last audit.
Standard 1.2.7: Human Resource Management	FA	Human resources policies include recruitment, selection, orientation, and staff training and development. Five staff files were reviewed (operations manager, clinical coordinator (registered nurse), assistant manager/relief cook; two caregivers/activities coordinators. Files included evidence of a recruitment process including reference checking, signed employment contracts, job descriptions, and completed orientation programmes. A register of registered

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. There is a low staff turnover. Performance appraisals were up-to-date in all staff files reviewed. The operations manager (registered nurse) and clinical coordinator nurses are supported to maintain their professional competency with attendance at DHB training. Both are interRAI trained. There is an annual training plan. All staff participate in continuing education and each staff file included an individual summary of attendance.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There are two caregivers in the morning and two in the afternoon (both have one long and one short shift) and two caregivers overnight on site (one on shift and one on call). Extra staff during the day include a rostered activities coordinator who works five hours a day, between 9.30 am and 3 pm, seven days a week. Staff working on the days of the audit, were visible and attending to call bells in a timely manner as observed during the audit. The operations manager lives on site and shares on call with the clinical coordinator. The clinical coordinator works between 32 to 35 hours a week. Staff interviewed stated that staffing levels are satisfactory and that the operations manager and clinical coordinator provide a lot of support. Residents and family interviewed also reported there are sufficient staff numbers to meet resident needs. All described the staff as respectful, engaging and always available.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses have been assessed for medication competency on an annual basis. Caregivers complete competency assessments for the checking and administration of medications. Education around safe medication administration has been provided. Staff were observed to be safely administering medications on both days of the audit. The service uses robotic rolls, and these are checked on delivery against the paper-based medication charts. Standing orders are not used. There were no residents self-medicating. The medication fridge temperatures have been recorded along with the ambient temperature of the room. Eye drops were dated on opening and all stock was within the expiry dates. The service uses an electronic device to record documentation of prescribing and administration of medication. Ten medication charts reviewed met legislative prescribing requirements. The GP has reviewed the medication charts

		three monthly. All medications had been administered as prescribed. Medications were stored securely.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals and baking are prepared and cooked on site by a cook, who is supported by the assistant manager/cook when not on duty. There is a four-weekly menu which has been reviewed by a dietitian within the last two years. Fridge, chiller, and freezer temperatures are taken and recorded daily. End-cooked food temperatures are recorded. Inward chilled goods have temperatures checked on delivery. Cleaning schedules are maintained. Chemicals are stored safely. Kitchen staff were observed to be wearing correct personal protective clothing. The food control plan is in place expiring 4 July 2021. Food services staff have completed training in food safety and hygiene The kitchen is adjacent to the dining room and meals are served directly from the kitchen to residents. Dietary needs are known with individual likes and dislikes accommodated. Additional or modified foods are also provided by the cook. Staff were observed assisting residents with their meals and drinks. Snacks are available for residents during the day. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required, GP, dietitian, or nurse specialist consultation. There is evidence that relatives were notified of any changes to their relative's health including accident/incidents, infections, health professional visits and changes in medications. Discussions with relatives and notifications were documented in the communications page in the resident record. Short-term care plans were documented for acute needs. Examples of short-term care plans were an acute oral health problem, bruising, pain in a shoulder, a scratch. Adequate dressing supplies were sighted in the treatment room. A wound register is maintained. On the day of the audit there was one stage one pressure injury. This was a reddened area and staff were actively working to ensure that this did not progress further. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for the pressure injury. Interventions required were readily available in the resident care plans, and monitoring charts were consistently recorded as instructed in the care plans. The incident reports reviewed had evidence of registered nurse follow-up with neurological observations completed according to the policy. Continence products are available and resident files included documentation of any needs with interventions documented.

		Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, restraint, and challenging behaviour. Three of the five resident records reviewed included documentation by external specialists or the GP that evidenced significant progress in health since they had been in the service. One record noted that the resident had put on weight, had less aches and pains, was sleeping better and was in much better mental health since being in the service. The resident confirmed that they were very happy with the service. Another resident had settled since admission and had not had challenging behaviour after a week or two of being in the service. Staff continue to reassure and monitor their whereabouts. The third resident record noted that the resident did not want to leave the service. They were engaged in the activities programme, stated that they felt their cultural needs were well met and said they would not want to be anywhere else.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service has a qualified registered diversional therapist (DT) who is the operations manager. They provide oversight of the programme. Caregivers are rostered as extra on the day, seven days a week for five hours a day. Caregivers also engage in activities during the day as sighted during the audit on both days. The auditor noted that residents had a lot of fun that included exercises, impromptu dancing to music, one to one activities and residents who chose to watch or sit nearby enjoying books or the sun. On the days of audit, there was a high engagement by residents in activities. An activity assessment and plan are completed on admission for each resident in consultation with the resident/family (as appropriate). The interRAI assessment and care plan from then on include documentation of individual needs and interventions. Caregivers interviewed stated that they loved working in the service as residents were so engaged and happy. All stated that they were able to have input into the care planning. The activity team provide individual and group activities in the rest home to meet the recreational preferences of the resident groups. The programme included exercises, board games, arts and crafts, sensory activities, word games, and walking groups. There are weekly outings in the van. Residents enjoy scenic drives to the airport, beaches, and outings to community. One-on-one activities are available such as individual walks, massage, reading, and pampering occurs for residents who are unable, or choose not to be involved in group activities. Community visitors include churches, entertainers, school groups, and others.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a	FA	Initial care plans reviewed were evaluated by the clinical coordinator or operations manager and all had been developed and reviewed within expected timeframes. Long-term care plans had been evaluated six-monthly in all records reviewed. The GP reviews residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and acute care needs forms. The evaluations involved the GP and residents/relatives if engaged with their family member.

comprehensive and timely manner.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness in place. Records of preventative and reactive maintenance are maintained. Equipment has been tagged and tested and medical equipment calibrated. Hot water temperatures have been recorded and are within expected ranges. The facility provides space for residents to wander around freely, and have access to the outside garden areas, seating, and shade.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Reports documented with graphs are discussed at bi-monthly staff meetings and at integrated management meetings. These show the numbers of infections against previous months and years. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. The operations manager and/or the clinical coordinator discuss trends and any opportunities for improvement with these documented in meeting minutes. There have been no outbreaks since the previous audit. The service has been awarded a continuous improvement for surveillance activities. This shows that the service has continued with the interventions and strategies demonstrated at the certification audit and added to these with the effectiveness of surveillance activities during the pandemic (Covid-19).
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices would only be used if it were clinically indicated and justified or where other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. There are no restraints or enablers used in the facility. Staff training is in place around restraint minimisation and enablers, and analysis and management of challenging behaviours.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and	CI	The operations manager, clinical coordinator and staff have increased surveillance activities to monitor potential Covid-19 and other infections during the pandemic and have actively documented and implemented strategies to ensure that residents, family, and staff are well supported and informed. The work commended around	The operations manager, clinical coordinator and staff have access on site to approximately three months’ supply of personal protective equipment in case of any resident or staff having Covid-19. There are detailed policies and processes documented to ensure that all are aware of what a pandemic is, what Covid-19 is, prevention strategies and a short-term care plan prepared in case of a probable or active case. The risk register has been updated to include Covid-19. The operations manager supported staff by shopping for staff online so that they did not have to come in contact with others outside of their bubble during level three and four. The staff have provided residents with information and have provided one-to-one training for them around Covid-19, hand hygiene and standard precautions. Staff have actively monitored residents’ vital signs with monitoring of these increased to twice daily during the pandemic and documentation in progress notes for each resident. The operations manager and clinical coordinator both attended DHB, Ministry of Health and World Health Organisation training online and via zoom meetings. The GP has remained in close contact with the operations manager and clinical coordinator to oversee and monitor residents and to provide advice and support. There is documentation to confirm that there has been communication with family members throughout the pandemic and family confirmed that the operations manager rings frequently to provide information and support them. Residents and family commended the operations manager on the

management in a timely manner.		surveillance at the last certification audit has continued.	way in which support has been provided during this time.

End of the report.