Villa RQI Update
Required Actions, Planning, Accountability and Sustainability

St. Joseph's Villa Dundas
February 1, 2018

Definitions of Levels of Non-Compliance:

a) **Written Notification**: Communication to the Licensee by an inspector that an area of non-compliance has been identified under the LTCH Act with specific detail on the section of the Act or Regulations this pertains to.

b) **Voluntary Plan of Correction**: The inspector can make a written request for the licensee to prepare a written plan of correction for achieving compliance to be implemented voluntarily. The licensee/Home is not required to submit the plan to the ministry. There is no required compliance date set out in the inspection report.

c) **Compliance order:** An inspector or the Director may order a licensee to do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act; or prepare, submit and implement a plan for achieving compliance with a requirement under the Act.

d) **Work and activity orders:** An inspector or the Director may order a licensee to allow employees of the Ministry, or agents or contractors acting under the authority of the Ministry, to perform any work or activity at the long-term care home that is necessary, in the opinion of the person making the order, to achieve compliance with a requirement under the Act.

e) **Written Notification and referral to Director:** The inspector may issue a written notification to the licensee and refer the matter to the Director for further action by the Director.

February 1, 2018 Notes: All strategies have been initiated and/or underway for identified improvement requirements. Many initiatives and strategies ongoing. These include education, audits and accountability of staff. We continue to audit these strategies, and follow up on areas of concern. Nursing standards and processes have been reviewed, and evaluation of mandatory programs and areas of non-compliance are ongoing. We continue to work on staff engagement in all areas, and increased communication with all stakeholders for practice changes. Education for staff continues in individual and group settings. We continue to strive for excellent care, compliance in all areas as per the MOHLTCH Act and Regulations.

	Areas of identified improvement requirements from MOH	Status		Strategies in place and/or underway for RQI follow up Green: Complete Yellow: Underway Green/Yellow: considerable work has been completed and more work is underway.	MOH Due Date
CO #1 WN #1	**Responsive Behaviour Management**				
1. **Sec. 53(2)**	• Ensure all responsive behaviours demonstrated by residents are acknowledged and an interdisciplinary plan of care is developed to manage the responsive behaviours. This shall include mood and behaviour patterns, the identification of triggers, reasonable goals of care, and resident specific interventions to be put into place to manage the behaviours being demonstrated. • Ensure referrals are made to specialized resources where required, and in a timely manner, including BSO • Ensure residents exhibiting responsive behaviours are included in the monthly behavioural rounds • Ensure when residents demonstrate responsive behaviours, staff are documenting the actions taken to respond to the needs of these residents. • Provide training to all registered staff and PSW's around the importance of the appropriate and complete documentation of resident behaviours, including flow sheets and DOS charting.			• All necessary staff to be re-instructed on responsive behaviours with a focus on acknowledging such behaviours through documentation on the progress notes and updating of the resident's interdisciplinary care plan. Re-instruction includes review of messaging behind responsive behaviours and management of these. Education through learning management system and through clinical educator. • Weekly Interdisciplinary Risk rounds initiated November 15, 2017. Rounds are new process, and are interdisciplinary in nature (nursing, medical director, pharmacist, therapy, chaplain etc.). Risk rounds review various residents with high risk concerns, including responsive behaviours and provide opportunity to assess and reassess residents weekly if required. Validated tools used for assessment for areas of risk for residents, and documented in electronic health record. Rounds have occurred weekly since November 15th, 2017. We on average see 10-15 residents per week. • Interdisciplinary review of each (RQI identified) resident's plan of care, to review mood and behaviour patterns, identification of triggers, set goals and interventions, along with reassessment dates of each intervention. • Re-instruct Registered staff re: the availability of external specialized resources for example; Geriatric Outreach services, PRC, Geriatrician, BSO and when to contact such services. Resident Care Coordinator staff overseeing referrals and process to ensure these external resources are completed and in a timely fashion. • Behavioural Supports Ontario external resource, actively involved with 45 residents in the home at present (Jan 18, 2018). BSO initiatives include recommendations for behaviour management and capacity building and education with staff. • Review of the RSKPOL10-Mgmt of Residents with Responsive Behaviours policy and program by an independent 3rd party for suggestions and input, completed October 25, 2017. • All applicants are screened prior to admission, for consideration of behavioural concerns using 'Disruptive High Risk Behaviour' screening tool. Home visits, site assessments and additional information are requested if there are flagged indicators.	• December22, 2017

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				• All residents assessed on admission and with significant change through new, 'Violence Assessment Tool'. Flagging system used to identify resident with potential high/imminent risk for violent behaviours, for staff awareness and management. Education to staff, resident and family council regarding new flagging program. • Resident home areas with higher risk, have had advanced 'Code White' call system installed to utilize in the event of emergency need or requirement of quick staff response. • Video cameras and screens installed for increased visibility of common areas by staff, so that monitoring of residents can be completed for various areas on the unit at the same time. • Focused audits by nurse management team randomly, to review resident who have had responsive behaviours to ensure process is followed and identify any areas of non-compliance. • Increased screening of all potential residents, including site visits, request for more information and if required, denial based on risk mitigation. • Accountability of staff, by the nurse management team in follow up to audit findings.	
CO #2 WN #2	**Plan of Care**				
2. **Sec. 6 (7)**	• Ensure that the care set out in the plan of care is provided to {identified resident} in relation to toileting routines initiated as part of the fall management program; in relation to pain management team consultation; in relation to pain management; in relation to provision of mouth care twice daily and storage of oral care supplies; in relation to the falling leaf program.			• All identified residents who require a toileting routine were reviewed to ensure such care is included in the resident's care plan. Any necessary changes or updates were immediately amended. • For specified residents, plan of care to be reviewed with interdisciplinary team including times of scheduled toileting as it relates to the resident's frequency and time of falls. • Resident with high risk of falls, or where falls have occurred are reviewed with interdisciplinary team at weekly rounds (new initiative), where validated tool based on Centre for Effective Practice data is used to review all potential contributing factors for falls, including toileting routines. • A review of specified resident's pain management protocols and care plan reviewed to ensure an interdisciplinary approach was utilized. Plan of care for pain management to be assessed with the interdisciplinary team, to assess, reassess and evaluate effectiveness of plan. • Residents with identified 'worsened pain' based on RAI/MDS data are reviewed weekly at risk rounds by interdisciplinary team, including medication review and non-pharmacological interventions such as	• December 8, 2017

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				positioning. Residents can be reviewed at risk rounds weekly as needed, to ensure assessment and reassessment of pain management. • All registered staff re-instructed on the home's policy re: pain management and the importance of utilizing an interdisciplinary approach in the management of resident's pain as well as ensuring such pain management protocols are set out in the resident's care plan through learning management system and clinical educator. • For identified resident, ensure that plan of care for contractures are followed. Random audits completed to ensure compliance with this. To date, random audits completed with 85% compliance to date. • Care staff to review the home's policy re: mouth care and storage of oral care supplies. Education to be initiated December 2017, and focused audits randomly occur for identified resident to ensure compliance. Audits to date show 57% compliance as of January 16, 2018. Ongoing correction strategies in place. • All care staff to be re-instructed re: the Villa's Falling Leaf program. Highlights placed in Friday Flyer communication and on resident home area boards for reference. • For identified residents, therapy team to ensure that Falling Leaf identifiers are placed on resident's mobility aid and on resident's name plate. Any changes in the resident's falling leaf program to be noted on the resident's care plan. Therapy and nursing staff working collaboratively to ensure indicators are in placed as required. Home wide audit in progress to ensure all identifiers in place. 100% compliance as of January 16, 2018. • Therapy Team attends weekly rounds, to ensure that all possible falls management strategies are in place for resident with high risk, or experiencing falls. • Interdisciplinary team completing post fall assessments for required residents and ensuring falls risk assessed with significant change.	
CO #3 WN #2	**Plan of Care - Reassessment of Implemented Interventions**				
Sec. 6(11)	• Ensure that residents who are at risk for falls, are reassessed and their care plans are reviewed and revised, and if the plan of care			• The interdisciplinary team to reassess, review, and revise plan of care for all residents at risk for falls. For those interventions not effective consider other approaches in the resident's care plan. This is completed during weekly interdisciplinary rounds for new residents with high risk of falls, or resident experiencing	• December 8, 2017

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	is being revised because care set out has not been effective, the licensee ensures that different approaches are considered in the revision of the plan of care. • Ensure that different approaches to be considered will include but not be limited to the monitoring of residents, the review of residents drug regimes, the implementation of restorative care approaches and use of equipment, supplies, devices and assistive aids.			frequent falls. Checklist used to ensure all possible impacts on falls are reviewed including environmental impacts, medications, equipment and current plan of care. Comprehensive assessment documented in individual resident electronic health record. • Effective November 14th, 2017 - Interdisciplinary Team to review residents at high risk for falls at weekly at rounds to address possible gaps and review alternative interventions as appropriate. • All care and therapy staff to be re-instructed re: different approaches in falls management. Education in process through clinical educator, and on annual mandatory online learning management system. • Staff to utilize current falls rounds checklist, which includes review of different approaches, medications, devices, environment etc. Any changes re: the resident's falls management program in the resident's care plan will be followed-up during risk rounds. Checklist based on validated tool through Centre for Effective Practice. • Focused audits to ensure falls care plans are clear, relative and followed by clinical educator and RAI team. Facility wide falls care plan audit completed December 2017 to ensure 100 % compliance with falls plan of care. • Review of falls policy, as well as data from internal and external resources reviewed; best practices changes made to align with system partners and MOH Act and Regulations.	

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CO #4 WN #3	**Skin and Wound**				
Sec. 50 (2)	• Complete an evaluation of the homes skin and wound care program and identify strategies to ensure all residents at risk of altered skin integrity receive a skin assessment by a member of the registered staff within 24 hours of the resident admission and upon any return of the resident from hospital. • Develop strategies to ensure a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears, or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, is assessed by a registered dietician, who is a member of the staff of the home ensuring any changes made to the residents plan of care related to nutrition and hydration are implemented and ensure that the resident is reassessed at least weekly by a member of the registered nursing staff if clinically indicated. • Develop strategies to ensure that equipment, supplies, device and positioning aids are			• Interdisciplinary team to meet and complete an evaluation of the homes current skin and wound program, to identify strategies to correct areas of non-compliance, completed Nov 23, 2017. • Review of NURPOL11-Skin and Wound Management policy and program by an independent 3rd party for suggestions and input, completed October 25, 2017 • Re-instruct care staff of the current skin and wound management program and clarify roles, responsibilities and strategies by clinical educator and through electronic learning management system. • Create simple guidelines of step by step process for staff reference in relation to skin and wound management process, and ensure treatment binders are up to date and have available references. • Registered staff to ensure all residents, at risk of altered skin integrity receives a skin assessment within 24 hours of the resident admission and upon any return of the resident from hospital. Audits initiated with each new admission. Audits of weekly skin assessments initiated November 20th, 2017 - 18 letters sent to staff with re-instruction from November 20 -30th, 2017. December 1 to 14th, 2017 – 18 letters sent to staff for reinstruction. Audits and letters being completed weekly. • Supply room fully stocked with supplies, equipment etc., and review and re-instruct staff the current availability and storage of equipment, devices, supplies and positioning aids. Wound care supplier changed, and stock readily available and restocked regularly. Registered staff has access to such supplies twenty-four hours per day, 7 days per week, and have been re-instructed on how to access after-hours. Policy updated to reflect this, nursing manager always on call for support if required. • Document all team meetings & maintain records regarding skin and wound care program will be recorded and maintained with the compliance order plan on the unit. Such records will include: record of evaluation and strategies for identified issues within the skin and wound program. Meeting minutes maintained. • Point Click Care user defined assessments (UDA) which are used to perform assessments related to skin and wound management, can be customized to meet current SJV needs. Using a multidisciplinary approach, this clinical tool will be reconfigured by the end of February 2018 to ensure all steps of the process identified in SJV policy NURPOL11 are completed before the assessment can be closed and locked. This will	• December 29th, 2017

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	readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing. • Keep a record of the evaluation and strategies undertaken for identified issues within the skin and wound care program. • Develop and implement audit tools to ensure that assessments and referrals are completed as per applicable regulations and to ensure that appropriate supplies are available as required by the resident with altered skin integrity.			help staff to complete all necessary steps. • Weekly audits occurring of treatment records, to ensure weekly skin assessments are completed as required. Standard letter of re-instruction sent to staff if non-compliance identified with assessment. If staff member has repeat concerns, progressive discipline may apply. Decrease in number of letters sent to staff related to non-compliance.	
CO #5 WN #4	**Policies – Implementing and following own policies**				
Sec. 8 (1)	• As part of the falls prevention policy ensure that the HIR is completed for all unwitnessed falls where the resident is unable to accurately report if they hit their head. • As part of the responsive behaviour policy, to ensure that the substitute decision maker is notified when an aggressive resident to resident occurs. • As part of the medication management policy, ensure that the drug record book is maintained including documentation of			• All registered staff to be re-instructed on the Home's falls prevention policy to ensure that the HIR is completed for all unwitnessed falls where the resident is unable to accurately report if they hit their head. Education sessions through clinical education and learning management system. • All care staff to be re-instructed on SJV responsive behaviour policy with an emphasis on ensuring that the substitute decision-maker is notified when an aggressive resident to resident altercation occurs. Education initiated November 16th by clinical educator, and through annual mandatory learning management system. • All registered staff to be re-instructed on SJV medication management policy to ensure the following: a) Drug record book is maintained including documentation of meds ordered when faxed to pharmacy and when received from pharmacy b) Ensure that wasted narcotics will be disposed properly including witnessing by 2 registered staff. Narcotic forms auditing weekly.	• December 29th, 2017

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	medications ordered when faxed to pharmacy and when received from pharmacy, ensure that wasted narcotics will be disposed of properly including witnessing by 2 registered staff. • As part of the homes resident admission, transfers, return from hospital assessment, ensure that head to toe assessments are completed on the shift of the residents arrival from hospital. • As part of the homes policy that provided for written procedures for dealing with complaints, ensure that complaints are documented accurately and that complaint logs are maintained. Complaints are to be audited quarterly with a record kept of audits kept.			• Memos placed on units, and reviewed with staff. Focused audits initiated in November and are ongoing regarding identified medication management concerns. To date, narcotic audits being completed as well as medication safety and storage audits. From October 2017 to present, 255 audits have been completed with 78% compliance noted. • Drug record book to be monitored by all registered nursing staff, to ensure completion of required documentation for signing in/ordering medications as well as audits by pharmacy quarterly. Audits being completed by nurse management team to monitor compliance. • Medication Management in-services occurring for registered nursing staff, initiated December 2017. • Electronic Medication Administration Record (EMAR) trial began November 15th on Convalescent Care Unit. Plan for roll out Villa wide which will include scanning of medications and elimination of paper drug record book. November 27, 2017 - Trial completed and new system working well. Plan for Villa roll out begins March 2018. • All registered staff to be re-instructed re: the home's resident admission, transfers, return from hospital assessment with the completion of the head to toe assessment on the shift the resident arrives home from hospital. Audits completed with new admissions through RAI department, to ensure completion. • Staff to be re-instructed on the Home's complaint process with an emphasis on ensuring complaints is documented accurately and logs are maintained. Review of complaint policy completed in December and reminder and education placed in communication bulletins. • The Villa's current complaint process is posted on each unit, family information board and noted in the resident admission Welcome Booklet. Communication binders have been created for families and residents for each unit, to ensure information is easily available on all resident home areas. • A reminder of the Villa's complaint process will be provided via the 'Friday Flyer'. • Currently all complaints and concerns are forwarded to the Director of Quality for review and follow-up through collaboration with the respective departmental manager(s). All concerns are documented and logged. • Currently one of the Villa's QIP indicators is: percentage of same day complaint resolution. Currently the	

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				• Villa has surpassed the target goal of 30% complaints addressed on the same day quarterly. To date the Villa has averaged 59% concerns addressed on the same day per quarter. (from 2016 Q4 – 2017 Q3) • Focused audits to be performed related to specific policies, and deviation from expectation will be automatic follow up from Nurse Management Team.	
CO #6 WN #5	**Duty to Protect**				
Sec.20	• Ensure that their written policy to promote zero tolerance of abuse and neglect for residents is complied with including but not limited to the duty under section 24, to make mandatory reports.			• All staff to be re-instructed re: the Home's policy and legislation re: zero tolerance of abuse and neglect through online learning management system and face to face in-services by clinical educator. Initiated November 2017 and re-instruction in-services completed. • A decision tree reference developed for front line staff for easy reference: this decision tree includes: a) reporting requirements b) when to contact on call nurse manager. November 16, 2017 - Decision tree completed, posted. • Decision Tree to be introduced at all nursing meetings by November 30, 2017 as well as posted on all units. Nursing meetings occurred on November 2017, and have increased to occur with monthly meeting and monthly education sessions. • Currently Nurse Management team are reviewing documentation daily. Any noted concerns will be discussed daily with nurse management team during daily team huddles. New Nurse Management daily 'Team up for 10' huddles occurring Mon – Fri for increased communication with team. • We are seeing an increase in reporting of Critical Incidents – for example, in January 2017 – 1 incident reported, for January 2018 – 9 incidents reported. This is related to increase in communication and awareness of reporting requirements. • Any documented incidents which have not been reported per policy, to be reviewed and followed- up with staff to ensure all required reporting is completed as required. • Nurse Management team reviewing and submitting all required incidents to MOH as required. No late or missed reporting since process in place. • Resident with increased risk for responsive behaviours reviewed at weekly interdisciplinary risk rounds with goal to mitigate risk of potential resident to resident abuse.	• November 30, 2017

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WN #6 – #18 (VPC)	**Devices; Staffing Plan; Assessment; Continence; Weight Changes; Meal Service; Hazardous Substances; Seatbelts; Medication Management; Infection Control**				
	• Is hereby requested to ensure that all staff used all equipment supplies, devices, assistive aids and positioning aids in accordance to manufacturer's instructions. • Is hereby requested to ensure that the staffing plan (a) provided for a staffing mix that is consistent with the resident's assessed care and safety needs and that meets requirements set out in the Act and this Regulation • Is hereby requested to ensure that when a resident has fallen, the resident is assessed and is required a post fall assessment is conducted. • Is hereby requested to ensure that each resident who is incontinent has an individualized plan as part of his or her plan of care to promote and manage bladder and bowel continence based on his/her assessment and that the plan is implemented. • Is hereby requested to ensure that residents with weight changes as per r.69 are assessed			• All nursing and therapy staff to be re-instructed to use all equipment, supplies, devices, assistance aides and positioning aides in accordance to manufacturer's instructions. Manuals being developed for each unit with all relative manufacturers' instructions, along with education specific to equipment management. • All nursing and therapy staff will follow manufacturer's instructions when using equipment, supplies, devices, assistance aides and positioning aides. Audits to ensure proper application and use of devices to be completed by therapy team. For the months of December 2017 and January 2018, we have achieved 94% compliance. • Currently the Nursing envelope is subsidized through Other Accommodation envelope to ensure adequate staffing and resident needs are met. • Presently the Villa's Case Mix Index (CMI) is less than the Provincial average. In order to maximize the nursing and personal care funding the following been implemented: a) A review of the each unit's CMI score to determine degree of acuity of residents and care requirements. b) The identification of key champions on each unit to support the RAI department re: coding and documentation. c) Data quality audits completed by RAI Coordinators prior to quarterly submission of RAI data to ensure coding accuracy – this is common practice, however further collaboration between the three LTCH's has taken place to further develop and enhance current strategies • Additional staff (4 hours daily) added to secure home areas, where noted behaviours are most acute, and additional 8 hours overall to home areas with highest CMI/care needs. Total of 24 hours daily of additional PSW hours added since October 2017. • Effective April 2018, 13 current part time/ temporary positions will become full time permanent positions. • All registered staff will be re-instructed on the home's post fall assessment policy.	• December 29, 2017

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	using an interdisciplinary approach and that actions are taken and outcomes are evaluated. • Ensure that the home has a dining and snack service that includes at a min. the following elements (1) course by course service for each resident (2) provides residents with any eating aids, assistive devices, personal assistance and encouragement to safely eat and drink at comfortably and independently as possible (3) appropriate furnishing and equipment is dining areas including comfortable dining room chairs and table at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. • Ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times • Ensure that seatbelts are applied according to manufactures guidelines • Ensure that drugs are stored in an area or medication carts that is used exclusively for drugs and drug related supplies • Steps are taken to ensure the security of the drug supply including the following; all areas where drugs are stored are kept locked at all			• Registered staff to complete a head to toe assessment immediately following any fall, Resident Care Coordinators will conduct a post fall assessment within timely fashion on incidents related to falls. • All registered staff will be re-instructed on the home's policy re: bladder and bowel continence program. • All residents identified with a bladder and bowel continence issues will have an individualized care plan to promote and manage his/her continence. To be completed by registered staff • All care staff to be re-instructed re: Home's policy re: weight changes among residents. • The Dietitians will review all weights monthly and will address any significant weight variances immediately through collaboration with the interdisciplinary team. Actions and outcomes to be evaluated ongoing until resident's weight is under control. • All staff (nursing and dietary) to be re-educated on fine dining experience and snack service for residents. Review of meal times and service, to review possible options to create relaxed dining experience. • The following areas will be reviewed; Course by course service; The provision of residents with proper eating aides, assistive devices, personal assistance and encouragement to safely eat and drink independently as possible; Provision of appropriate furnishings and equipment e.g: comfortable chairs, appropriate table heights. *Please note:* 6 feeding stools were purchased and received in August 2017. • All staff to be re-instructed on the Villa's hazardous substances policy and the importance of keeping such items inaccessible to residents. All hazardous items will be inaccessible to all residents. • Purchase of key pad locks for all clean and soiled utility rooms completed 2017. Key pad eliminate concerns with key use, doors propped open and accessibility to areas with potential hazardous substances. • All care staff to be re-instructed to the use of seatbelts based on the manufacturer's guidelines effective immediately. All staff to apply all seat belts according to manufacturer's guidelines. Audits initiated October 2017 weekly by therapy. For the months of December 2017 and January 2018, we have achieved 94% compliance to date. • All Registered staff to be re-instructed on the proper storage of drugs including drug related supplies as well as medication room and medication cart safety. • All registered staff were re-instructed that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and drugs are administered in accordance with the	

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	times while not in use. • Ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and drugs are administered in accordance with the directions for use specified by the prescriber • Ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug. • Ensure that staff participate in the implementation of the infection prevention and control program			directions for use specified by the prescriber. • All registered staff to be re-instructed on the importance of monitoring and documentation of residents taking any drug or combination of drugs, including psychotropic drugs. Documentation to include: a) The resident's response and b) The effectiveness of the drugs appropriate to the risk level of the drug. • All registered staff will ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug. • All staff to be re-instructed on the importance of participating in the implementation of the infection prevention and control program. • Focused audits on all areas of identified concern. In addition, pharmacy provider to complete specific audits quarterly, outcomes to be reviewed with the Medication Management Committee.	
WN #19-#29	**Bedrails; Sexual Behaviours; Plan of Care; Required Programs; Complaints; Critical Incident Reporting; Construction Renovations**				
	• Bedrails – entrapment audits with system changes, plan of care • Protection from abuse/neglect, specific to sexual behaviours with resident with cognitive impairment • Plan of care, specific to safety risk (seatbelt) • R/T all programs, emphasis on assessment, reassessment , interventions and resident			• All bed system changes to have entrapment audit as per SJV policy and MOH expectations, by the Resident Care Coordinator staff, and documented in the plan of care. • All residents with sexual responsive behaviours will be managed in a way that protects others from abuse utilizing specialized resources as necessary. • Plan of care for each resident to be reassessed at a minimum quarterly, and with any changes. RAI department to audit care plans with each quarterly submission for accuracy. • Care plans to be updated accordingly, including any change in equipment use. • Complaints will be documented in the electronic health record, and a quarterly summary of complaints will	• December 29th, 2017

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	responses are documented – *documentation / blank flow sheets /DOS • Belt change from front to side and care plan did not reflect this. • Seat belt, alternatives to this not identified • Complaints • Critical Incidents • Annual Evaluation, specific to Medication Management (analysis of incidents etc.) • Medication Incidents • Construction Renovations – specific to dietary (flooring in dish washing room)			be completed by the Director of Quality. • All critical incidents will be reported as per 'Reporting Certain Matters to the Inspectors', within time frames and with required information and review of what incidents must be reported/reviewed with staff. Education completed and ongoing. No late reporting since place in process. • Annual evaluations for all mandatory programs to be completed and reported/reviewed at Continuous Quality Improvement committee. Medication Management evaluation to include ISMP self-assessment, completed December 2017. • New seat belts for all bath chairs ordered and installed December 2017. • All medication incidents will be recorded in the online system, and followed up on by the DOC and ADOC. Incidents will be reviewed for trends and reported/reviewed at Medication Management and CQI committees, areas of education focus and any identified themes. • All construction will be reported to the MOH as per the MOH 'Operators Guide and Process for Alterations, Renovations or Additions to Existing Long-Term Care Homes'. No construction to date. • Focused audits will be completed to ensure compliance with the above noted areas of non-compliance.	