Villa Compliance Action Plan
Required Actions, Planning, Accountability and Sustainability Measures

Summary:

The Ministry of Health and Long Term Care (MOHLTC) arrived August 20, 2019 until September 27th, 2019 to complete a complaints and critical incident inspection. There were 4 inspectors, on site for a total of 23 days. There were 7 compliance orders, 11 written notifications and 4 voluntary plans of corrections issued within this reports. There was one report received for this visit, with a secondary amended report received.

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.

St. Joseph's Villa Dundas

SJV: MOHLTC Compliance Action Plan

Date: January 13, 2020

Inspection Number 2019_560632_0020 (A1) **Order/WN/ VPC**	**Specifics of Act/ Regulations & Specific requirements defined in order report**	**Resident # (if applicable – internal only)**		**Mitigation / Action Plan (Plan for resolving non-compliance)**	**Accountability (Audits and Follow up and who is responsible)**	**Sustainability (Changes to process / policy / practice; ongoing audits)**	**MOH Due Date** **Green:** ***Complete*** **Yellow:** ***Underway***
CO #1 & WN#1	**The Licensee has failed to comply with O.Reg. 79/10, s.36. Every licenses of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.** **Specifically:** *1.Ensure staff working on Oak Grove home area use safe transferring techniques, when assisting residents' (specific and all others)* *2. Ensure all direct care staff working in Oak Grove home area receive retraining regarding safe transferring techniques when assisting residents (specific and all others).* *3.Estalish an auditing process to ensure that staff working in Oak Grove home area, using transferring devices or techniques to assist residents, are using safe techniques appropriate to the needs of the resident. (Specific residents only).* *4. Ensure documentation be retained of staff training and staff audit results.*	**#012** **#013** **#014** **#067**		Retrain all regular FT and PT staff who work on Oak Grove on use of safe transferring and positioning devices or techniques when assisting residents. Review policy and practice for safe lifts and transfers. M.J. to obtain list of all FT and RPT staff. M.T. and PSW M.S. to complete training January/February 2020.	Audit to be completed on safe transferring techniques of staff on Oak Grove for specified residents. Two audits weekly to be completed by NM team or delegate and documentation kept with Director(s) of Care. Observation audits to include 4 specific residents and 6 random residents – to be completed by A.M and M.J.	Provide re-training to all direct care staff in 2020 on safe lift and transfer policy and training. Create 'super trainers' for lift training. Once compliance is achieve, continued random audits to be completed and documented. J.W. to complete audit tool based on relative Act/Reg's/I.P's for ongoing audits.	**April 20, 2020**
CO #2 & WN #2	**The Licensee has failed to comply with O.Reg. 79/10, s. 71. Menu planning. Specifically failed to comply with the following:** **s. 71 (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily;** **s. 71(3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.** **Specifically:** 1. Ensure that identified residents and all others are offered breakfast daily. 2. Ensure that identified residents and all others are offered a between meal beverage in the morning. 3. Develop and implement an auditing system to identify if residents are offered breakfast and a minimum of a between-meal beverage in the morning. 4. Maintain the documentation of the auditing system.	**#010** **#011** **#027** **#028** **#029** **#030** **#031** **#032** **#033** **#034** ***All others**	**#010 to #049** ***All others**	Complete review of meal and snack process, including meal times and staff duties and assignments for food service. Review policy and standard regarding meal service. Develop auditing system for meals and snacks.	Audits to be completed on specific residents and random other residents to ensure that breakfast and mid-morning beverage is provided. Audits to be completed weekly by nurse management team or delegates in collaboration with food services team. Documentation of the audit to be kept with the Director(s) of Care. Meal choice list to be used for audit tool. Each RCM to complete one home areas weekly for breakfast audit (in DR/T for tray/offered/refused). Nsg Admin to complete morning beverage audit – one tower per week, using juice list as audit tool.	Review meal and snack service as part of larger staffing review. Once compliance is achieve, continued random audits to be completed and documented. Random flow sheet audits to be completed by NM team. Review PSW roles, job routines, night shift care provision.	**April 20, 2020**

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CO #3 & WN#3	**O. Reg. 79/10, s. 31. (3) The staffing plan must,** **(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;** **(b) set out the organization and scheduling of staff shifts;** **(c) promote continuity of care by minimizing the number of different staff members who provide nursing care and personal support services to each resident** **(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including staff who must provide the nursing coverage requested under subsection 8 (3) of the Act, cannot come to work; and** **(e) be evaluated and updated at least annually in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices.** **Specifically:** 1. Provide for a staffing mix that is consistent with resident assessed care and safety needs and that meet the requirements set out in the Act and Regulation 2. Ensure adequate staff mix of registered staff to properly administer medications 3. Ensure adequate staff mix of personal care staff to ensure that residents are bathed at a minimum of two days a week by the method of their choice, including two tub baths, showers, and full body sponge baths, and more frequently as determined by the residents hygiene requirements, unless contraindicated by a medical condition. 4. Ensure adequate staff mix of personal care staff to ensure that all residents are offered a breakfast daily. 5. Ensure adequate staff mix of personal care staff to ensure that all residents are offered a minimum of between-meal beverage in the morning. 6. Have a back-up plan for personal care staffing that addresses situation when staff, including the staff, who must provide the nursing coverage, cannot come to work.		Complete review of personal care staffing, with third party Quality Consultant (Initiated August 2019) which includes front line staff, management team and staffing office delegates. Review staffing plan at mix other LTC sites, as well as annual evaluation of this. Complete review of roles and responsibilities of personal care support staff and other direct care staff. Review vacant positions and lines for opportunity to create new positions for coverage and consistency. Complete review of staffing software and rules built into this software. Staffing policies and practice revision in process. Develop 2020 recruitment plan. Staffing office changes for better coverage.	Complete weekly pro-active at a glance of staffing for planning purposes, to be completed by the staffing supervisor and submitted to the Executive team. Review of vacant lines and posting monthly, to be completed by the staff supervisor and submitted to the Executive team. Development of contingency plans for staffing coverage for each department.	Complete review of staff practices and policies through third party Quality Consultant and make changes to these accordingly to meet Act and Regulations. Review process for open lines and roles of HR and staffing.	**April 20, 2020**
CO #4 & WN#4	**O.Reg. 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**	**#021** **#076** ***All others**	Education will be completed to all registered staff by November 29th, 2019 regarding Medication Incident Reporting. *Completed*	Nurse Management team to complete all medication error follow ups, complete analysis and report at Medication	Nurse Management team to complete all medication error follow ups, complete quarterly analysis and report at	**November 29, 2019**

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	(a) documented, together with a record of the immediate actions taken to assess and maintain the residents health; and (b) reported to the resident, the residents substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the residents attending physician or registered nursing in the extended class attend the resident and the pharmacy service provider. **Specifically:** 1) Ensure that every medication incident involving specific residents and all others residents is documented, together with a record of the immediate action taken to assess and maintain the residents health and reported as per O. Reg. 79/10, s 135. 2) Ensure that all registered staff are provided education related to need to complete Medication Incidents Reports for all mediation incidents and ensure that a written record of staff attendance is maintained in the home.		*~99% completed as of November 29, 2019. Remaining 4 staff are on Leave of Absence with plans to complete upon return.* Education for Registered staff – Presentation to be completed by NM team, and attendance documentation submitted to and maintained with the Director(s) of Care. Review of med incidents for residents #021 and # 076, Completed November 2019. Review of medication incident policy and practice – Completed November 4, 2019. Internal timelines and practice established. Review Progress Note template in electronic documentation for medication incidents. Meet with Medical Director re: process for med incidents. He will now receive all emails from pharmacy for all medication incidents, as well as review these at Medication Management – email notification completed October 30, 2019. Standard for Medication Administration reviewed and updated – completed November 6, 2019.	Management. Medical Director to follow up with physicians regarding medication discontinuation practices.	Medication Management Committee. Pharmacist to complete review of units with heavier medication passes, to look at areas for improvement – ongoing. Review of average number of medications per resident quarterly at committee level – ongoing. New medication incident tracker for January 2020.	
CO #5 & WN#5	~~**LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty to provide for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.**~~ ~~**Specifically:**~~ ~~1. Notify residents and/or their SDM's of every alleged, suspected or witnessed incident of abuse and or neglect of a resident by the licensee or staff.~~		Memo and education has been previously completed with staff and teams regarding reporting to the Director. Memo for this has been recirculated.	Review of all incidents reported to the Director in 2019 to date.	***Please note this order was appealed on the grounds that the information received was not provided in the context of resident abuse or neglect, and was followed up on.** ***Appeal Denied.**	**April 20, 2019**

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	~~2. Immediately investigate every alleged, suspected or witnessed abuse and or neglect of a resident.~~ ~~3. Ensure where the licensee has reasonable grounds to suspect that abuse and or neglect of a resident has occurred or may occur the suspicion and the information upon which it is based is immediately reported to the Director MOHLTC.~~ ***Order updated post appeal:*** ***S. 24 (1) of the LTCHA –*** ***(1) Where the licensee has reasonable grounds to suspect that improper or incompetent treatment and / or abuse or neglect of a resident has occurred or may occur, the Licensee shall immediately report he suspicion and the information upon which it is based to the Director.*** ***(2) All staff must follow the homes process for reporting under the homes policy on Prevention of Abuse/Neglect of a Resident*** ***(3) All staff should receive training on the homes policy on Prevention of Abuse/Neglect, specifically the process for reporting to the Director.***		*Complete education for all staff on home's policy on Prevention of Abuse/Neglect of a Resident and specifically the process for reporting to the Director.*			
WN#6 & CO #6	***Order updated post appeal:*** **The Licensee failed to comply with O. Reg. 79/10, s 131. Administration of drugs s. 131(1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident & (2) The licensee shall ensure that drugs are administered to a resident in accordance with the directions for use specific by the prescriber.** **Specifically:** 1. Ensure that no drugs are used by or administered to specific residents and all other residents, unless the drugs have been prescribed for them. ~~2. Ensure that drugs are administered to specific residents and all other residents in accordance with the directions for used specified by their prescriber.~~	**#021** **#053** **#075** **#078**	General review of medication incidents for residents #021, #053, #075, #078, Education provided to all registered staff regarding minimizing interruptions during medication passes and safety. Sign created for mediation carts when medication passes are in process. Review completed for all residents with like name - Name Alerts process. Completed November 2019. Review of medication incident policy and practice – Completed November 4, 2019. Internal timelines and practice established Standard for Medication Administration reviewed and updated – completed	Ensure tracking tool of Registered staff doing floor and half and which staff are impacted. Staffing office to maintain this audit tool. Medication pass audits being completed by ADOC, and maintained with DOC. **Please ensure Jenny's audits for CO#6 and CO #7 are specific to listed residents!	***This order was appealed on the grounds that full process and procedure was followed for a medication error as per best practice guidelines and for residents impacted, and there was minimal harm to residents involved. Incidents of error were self-reported and Just Culture practices followed.** ***Appeal Denied** Nurse Management team to complete all medication error follow ups, complete quarterly analysis and report at Medication Management Committee.	**November 29, 2019**

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			November 6, 2019.			
WN#6 & CO #7	**The Licensee failed to comply with O. Reg. 79/10, s 131. Administration of drugs s. 131(1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident & (2) The licensee shall ensure that drugs are administered to a resident in accordance with the directions for use specific by the prescriber.** **Specifically:** 1. Ensure that drugs are administered to specific residents and all others in accordance with the directions for use specified by the prescriber. 2. Conduct an audit to ensure that drugs are administered to specific residents and all other residents in accordance with directions for use specified by the prescriber. 3. Keep documentation records of the audits conducted to ensure that drugs are administered to specific residents and all other residents in accordance with the directions of use specified by the prescriber.	**#074** **#076**	General review of medication incidents for residents #074 and #076. Education provided to all registered on medication incidents, risk and error reduction techniques. Review of medication incident policy and practice – Completed November 4, 2019. Standard for Medication Administration reviewed and updated – completed November 6, 2019.	Audit of specified residents to be completed weekly by the Assistant Director of Care and submitted and maintained by the Director of Care. Medication pass audits being completed by ADOC J.W. to J.N with development of specific audit tool.	Once compliance is achieve, continued random audits to be completed and documented.	**November 29, 2019**
WN # 7	**LTCHA, 2007 S.O. 2007, c.8, s.6 Plan of Care**		1.Plan of Care was not based on resident preferences (bathing) 2. Plan of Care not followed (transfers, 1:1 staffing)			**No compliance date provided.**
WN # 8	**O. Reg. 79/10, s. 8. Policies to be followed**		1.Policy not followed (pain assessment, PEG feed, Code Blue		**Education for 2020 Surge on Code Blue / CPR.**	
WN #9	**O. Reg. 79/10, s. 33. Bathing**		1.Bathing preference not provided			
WN #10	**O. Reg. 79/10 s. 73 Dining and Snack Service**		1. Personal Support Staff not present in dining room.		**Review of PSW roles, assignments etc.**	