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

Summary:

The Ministry of Health and Long Term Care (MOHLTC) arrived October 17, 2019 to complete a complaint and critical incident inspection. The inspections finished on November 8, 2019. There were 3 inspectors on site for a total of 17 days. A report for each inspection was received on and dated November 22, 2019.

The complaint inspection resulted in 3 WN's 2 VPC's and 1 CO. The critical incident inspection resulted in 7 WN's, 5 VPC's, and 2 CO's.

The following previously issued order was found to be in compliance at the time of the inspection, and was cleared – O. Reg. 79/10 CO #001 (related to weight loss)

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 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*
Complaint Inspection 2019_661683_0021						
CO #1 & WN#1	**O. Reg. 79/10, s. 134. Every licensee of a long-term care home shall ensure that, (a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring a documentation of the residents response and effectiveness of the drugs appropriate to the risk level of the drugs; (b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs and (c) there is , at least quarterly, a documented reassessment of each residents drug regime.** **Specifically:** 1. Ensure specific residents and all resident who are prescribed Warfarin have the INR monitored at the determined frequency identified by the physician and/or the homes Med-e-INR system. 2. Ensure that all incidents of INR's no completed as required are documented as a medication incident. 3. Develop an auditing tool of the Warfarin Therapy Record to determine if residents who are receiving Warfarin are having their INR monitored. The audit should include, but is not limited to, associated orders and lab work, and is to be completed monthly. Records are to be maintained of the audits.	**#001 #015 #016**	Complete audit of all residents receiving Warfarin therapy. Completed November 2019. Review of practice and policy for Warfarin therapy – complete November 2019. Develop Auditing tool per order specifications. Review of practice of all team members involved in Warfarin therapy order changes - completed November 2019. Review with pharmacy provided on Warfarin therapy usage and practice expectations – completed November 2019.	Audit to be complete monthly by the nurse management team or delegate, and records to be maintained by the Director(s) of Care. Clinical RPN role will take on all INR review in future, with increased use of Coagucheck versus lab work. RAI Coordinators completing audits per order at this time. **Please ensure we have these in writing per order	Review of overall practice of Warfarin therapy and review of responsibilities with this therapy. Oversight of all Warfarin therapy by nurse management team or delegate of team.	**December 6, 2020**
WN#2 VPC	**LTCHA 2007, S.O. 2007, c.8, s.6. Plan of Care s. 6. (5) The licensee shall ensure that the resident, the residents substitute decision maker, if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident plan of care.**	**#004**	Resident was prescribed antibiotic by physician and SDM had not consented to this.	**Allergic reactions, medication incidents and consent reviewed with education for MOH Action plan for visit 2.**	**Education and practice review in 2020 on Informed consent and part of Nursing Orientation**	**No compliance date provided.**
WN#3 VPC	**O. Reg. 79/10, s. 135- Medication incidents and adverse drug reactions.**	**#001**	Residents INR not completed, adverse drug reaction not reported as medication incident.			
Critical Incident Inspection 2019_661683_0020						
WN # 1 & CO #1	**LTCHA, 2007 S.O. 2007, c.8, s. 19 – Duty to protect** **Specifically:** **1. Protect specific residents and any other resident from abuse by specific resident or any other resident.**	**#009 #010**	Review of identified resident's plan of care. Review of policy and practice for Management of residents with Responsive	Audit completed to ensure that residents identified with high VAT, have care plan in place and identifying bracelet – completed November/December 2019.	*	**February 28, 2020**

Comment [ME1]: RAI will also do this for CCU clients at this time – were not on original audit list.

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			Behaviours Identified residents no longer reside in the same resident home area – issue, risk and concern has been mitigated.			
WN # 2 & CO #2 *Re-issue	**LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) Plan of Care Specifically: 1. Ensure that identified residents and all other residents are provided with their fall prevention strategies, as per their plan of care. 2. Develop an auditing tool to determine if falls prevention interventions are in place for specified residents as per their plan of care. The audit must identify, but is not limited to, the specific fall prevention interventions that residents require. The audit must indicate whether the interventions were in place for the identified residents at the time of the audit, and any corrective actions taken if identified interventions were not in place. Records are to be maintained of the audits, where are to be completed, at a minimum, monthly.**	**#008 #011 #012**	Development of auditing tool as specified in the order. Review of policy, practice and responsibilities for falls management and implementation of interventions. J.W. to create auditing tool for falls per order based on Act/Regs/IP's.	Audit to be completed for identified residents at a minimum of monthly by nurse management team or delegate and submitted and retained by the Director(s) of Care. Audit to be completed by Clinical RPN on template provided – for specific residents and those at random.	Ongoing audits for review and use of falls prevention strategies as per identified care plans. Review of current falls equipment, purchase of more items as needed.	**April 20, 2020**
WN #3 VPC	**O. Reg. 79/10, s. 8. Policies to be followed**	**#003 #008 #005**	Policies not followed for Fall Prevention and Management, including Head Injury Routine.		**HIR currently recorded on paper. PCC tool in place which will link directly to PCC note for documentation purposes.**	**No compliance date provided.**
WN#4 VPC	**O. Reg. 79/10, S. 26 (3) A plan of care must be based, at a minimum, on interdisciplinary assessment of the following with respect to the resident 19. Safety Risks**	**#001 #014**	Documented assessment for safety to be completed for identified resident - Resident going outside to smoke during night shift, resident leaving the property in motorized chair.	**Safety care plans for specific residents to be completed.**		
WN#5 VPC	**O. Reg. 79/10, s.140 Every licensee of a long-term care home shall ensure that each medical absence, psychiatric absence, causal absence of a resident of the home is recorded.**	**#014**	Resident had left the home, resulting in Code Yellow however resident had not signed out before leaving.	**Review of sign out process for residents. Review of signage etc.**		
WN#6 VPC	**O. Reg. 79/10, s231. Resident Records. Every licensee of a home shall ensure that (a) a written record is create and maintained for each resident of the home and (b) the resident written record is kept up to date at all time.**	**#005**	Resident progress note states HIR was being completed, however clinical record for HIR was not located.		**Clinical records to be placed on PCC where possible.**	
WN#7	**O. Reg. 79/10 – Reports re: Critical Incidents s. 107(3)**		Medication incident had been reported for missing controlled substance; however this had not been reported to the MOH as		**Education to team regarding reporting.**	

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			required.			