## MINISTRY OF HEALTH AND LONG TERM CARE 2015 RESIDENT QUALITY INSPECTION – MACASSA LODGE

| RQI Finding | Description | Action |
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| WN #1, CO #1 – Bedrails | Required pre-implementation policy development and staff education related to use of bedrails has been ongoing since the last RQI. | An implementation date of July 1, 2015 was pending when the Compliance Inspectors completed the RQI. Despite the acknowledgment of our pre-implementation efforts and the pending start date, a CO was issued. Ministry has indicated the full program must be implemented by September, 2015; this will be accomplished. |
| WN #2, VPC #1 – Plan of Care | Written plan of care sets out planned care, goals and clear direction for staff. | This is the most commonly issued WN across Ontario. Review of care planning with staff and increased audits by Nursing Leadership have occurred. Given the complexity of care and the exhaustive expectations related to documentation, it is probable that this written notification will continue to be a challenge for all LTC Homes, including Macassa Lodge. |
| WN #3, VPC #2 – Furnishings in good repair | Three single seat dining tables were noted to have small cracks which could present an infection control issue. | Tables will be replaced and audits of furniture completed across the Lodge. |
| WN #4, VPC #3 – Skin and Wound Program | Residents with skin or wound issues are to be assessed weekly by registered staff to evaluate interventions and support healing. | One resident did not have the assessment completed as required an deterioration in his skin condition was noted. Review with staff and increased audits have been completed. |
| WN #5 – Responsive Behaviours | Residents with challenging or responsive behaviours must have such | One resident did not have a comprehensive plan of care for these |

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| | information included in their plan of care. | behaviours although all interviewed staff was aware and implementing appropriate care. Review with staff and increased audits have been completed. |
| WN #6 – PASD | Residents with assistive devices that could limit their movement must have consent for such devices. | Consent for tilt wheelchairs has been received by our contracted Occupational Therapist but it was not sufficiently documented. New process and documentation implemented immediately. |
| WN #7 – Annual Heights | Annual heights are to be completed for all residents to aid in determining nutritional needs. | This will be started August 2015. Additionally, the Lodge will advocate having this regulation reviewed as evidence does not support the practice. |
| WN #8 & 9 – Menu Planning and Snack Service | Resident Council is to be offered the opportunity to comment on the menu plan and the timing for meals/snack service. | This was completed in the Fall of 2014 but documentation in the Resident Council minutes was insufficient and the Resident Council President could not recall the activity occurring. Documentation will be improved. |
| WN #9, VPC #6 – Weight Changes | Resident weight changes to be assessed using an interdisciplinary approach and actions taken. As outlined in previous WN, a number of residents with weight changes were not assessed accordingly. | New processes implemented and monitored. |
| WN #10, VPC #7 – Food Production | Standardized recipes and production sheets are to be available for all menus. | This non-compliance is now fully addressed. |
| WN #11, VPC #8 – Dining and Snack | Feeding assistance and the provision | Increase in dining room audits and re- |

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| Service | of feeding aids are to be provided as outlined in the resident's plan of care. A number of residents observed to not receive the care outlined as required. | education with staff has occurred |
| WN #12, VPC #9 – Housekeeping (cleaning) | Tubs without integrated disinfection systems must be cleaned manually. Review of manual cleaning and disinfection was provided. | New tubs installed in 2014/2015. |
| WN #13 – Plan of Care | Written plan of care sets out planned care, goals and clear direction for staff. | This is the most commonly issued WN across Ontario. Review of care planning with staff and increased audits by Nursing Leadership instituted. |
| WN #14 – Complaints | Any written complaint to the Home is to be forwarded directly to the Ministry. One written complaint 6 months after resident death was addressed with family but not forwarded to Ministry. | Re-education with Leadership team has been completed. Policy updated to reflect this expectation more clearly. |
| WN #15 – General Requirements | Assessments, interventions and resident responses to interventions must be documented. | A small number of occasions of toileting help were not fully documented. For context, Nursing Staff across the Lodge in the month of October 2014 documented a total of 444, 520 care interventions for the residents in our care. |
| WN #16 – Bathing | All residents are to be bathed at a minimum twice a week based on preference. Two resident baths were noted to be missed. | Review with staff and increased audits have been completed. |
| WN #17 – PASD | All assistive devices that the resident requires to improve function must be included in the plan of care. | A small number of resident care plans did not have this information although the assistive devices were provided to |

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| | | resident. Review with registered staff and increased audits have been completed. |
| WN #18 & 19 – Powers of Resident and Family Councils | If either Council advises the Home of concerns or recommendations the Home will respond in writing within 10 days. | Both Councils asked that the written notification just be included and reviewed at the next monthly meeting. This is considered non-compliance and therefore minutes are now circulated with Home's response within 10 days. |
| WN #20 – Menu Planning | Planned menu items must be available for residents and meet their needs. | One therapeutic menu item was not available for two residents. Increased audits completed. |
| WN #21 – Hazardous Substances and Resident Access | Hazardous materials to be labeled and secured away from resident access. Utility room found to be unlocked. | Review with staff and increased audits have been completed. |
| WN #22 – Resident Drug Regimes | When a resident is receiving antipsychotic medication a monitoring system is implemented. | Resident antipsychotic medication was being reduced with effect but insufficient supporting documentation. New process implemented. |
| WN #23 – Infection Prevention and Control | Staff must participate in the implementation of this program. | One staff was noted in dining room not having washed their hands between serving different residents. Review with staff and increased audits have been completed. |