This Inspection Guide provides ***guidance*** to the inspector during the initial planning of an inspection. Not all sections will be applicable in every situation and the inspector may need to adjust the inspection based on information collected.

PROFILE FOR RESIDENT

- Name, room number, home area
- Date of birth, date of admission, date of discharge (if applicable)
- Diagnoses
- Other resident information, as applicable: Physician, SDM, Advanced Directives, Activities of Daily Living, and RAI-MDS Outcome Scores, e.g., CPS

CLINICAL RECORD REVIEW (ELECTRONIC AND HARD COPY)

ASSESSMENTS

- RAI-MDS - related to the specific concern.
- Assessments related to the specific concern, e.g., restorative care, skin and wound, continence care, end of life, foot care, therapy services, transferring and positioning, etc.

PLAN OF CARE

- Confirm the 24 hours admission care plan has been completed as required.
- The plan of care was completed, reviewed, and revised as required.
- The plan of care was based on resident's assessment and preferences, provided clear direction to staff, and care was provided to residents as per the plan of care.
- The plan of care interventions has been implemented and documented.

MEDICATION ADMINISTRATION RECORD (MAR)

- Medications provided as ordered.

TREATMENT ADMINISTRATION RECORD (TAR)

- Treatments provided as ordered.

PROGRESS NOTES

- Notes related to the concern being inspected.

OBSERVATIONS

- Resident to resident and staff to resident interactions.
- Care and/or assistance provided with respect, dignity, and privacy.
- Care provided to resident as per the plan of care.
- Supportive and assistive devices are being used safely and as indicated in the plan of care.
- Equipment and supplies are available as needed.

INTERVIEWS

RESIDENT/SDM

- Discuss with resident their personal care needs/concerns, if care is being provided as planned with dignity, choice, and privacy.
- Discuss if staff assistance is provided in a timely manner.

DIRECT CARE STAFF

PSW and others as applicable

- Discuss accessibility to the plan of care and the communication if resident's care needs or changes to interventions.
- Confirm care is provided as per the plan of care, safely, and with respect, dignity and privacy.

REGISTERED STAFF AND MEDICAL PERSONNEL

- Confirm the plan of care is based on the resident's assessed needs and preferences.
- Discuss accessibility to plan of care and the communication if resident's care needs or changes to interventions.

- Confirm care is provided as per the plan of care, safely, and with respect, dignity and privacy.
- Confirm the plan of care is reviewed and revised as required.

MANAGEMENT

Director of Care, Administrator/Delegate

- Discuss specific concerns.
- Confirm the home's expectation related to specific concern.
- Discuss the legislative areas of concern if identified.

OTHER RECORD REVIEW

- Relevant policies and procedures.
- General programs requirements and evaluations.
- Required training and retraining.
- Staff qualifications.
- Risk management or internal incident reports.
- Video or other visual or audio recordings.
- Other records, e.g., bath schedules, call bell logs, etc.

FOR FURTHER GUIDANCE

Please refer to policies, guidance documents, and job aids available in the eInspectors' Handbook.