Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 10, 2016	2016_334565_0001	036309-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Norfinch Care Community
22 NORFINCH DRIVE NORTH YORK ON M3N 1X1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MATTHEW CHIU (565), JANET GROUX (606), NITAL SHETH (500), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 18, 19, 20, 21, 22, 25, 26, and 27, 2016.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection: 008867-14 and 016485-15.
The following Critical Incident Intake was inspected concurrently with this Resident Quality Inspection: 020725-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Managers (NMs), Registered Dietitian (RD), Director of Dietary Services (DDS), Dietary Aide (DA), Cook, Food Services Supervisor (FSS), Residents Relation Coordinator (RRC), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeper, Corporate Human Resources Partner (CHRP), Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **11 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect a resident from abuse by anyone.

As per the Long-Term Care Homes Act, 2007:
- Emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks that are performed by anyone other than a resident, and
- Verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A review of critical incident report and the home's investigation records revealed on an identified date, when a family member visited resident #013, he/she overheard PSW #140 and #141 verbally abuse the resident. The family member informed another family member who reported the incident to the home later.

A review of the Notice of Discipline issued to PSW #140 and #141 indicated the details brought forward about the staff members' actions on the identified date have been substantiated, deemed inappropriate and demeaning, and are in violation of the home's policies.

Record review of resident #013's plan of care and Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment indicated the resident was able to express his/her likes and dislikes despite being cognitively impaired.

Interviews with two family members confirmed when the family member visited resident #013 on the identified date, he/she witnessed PSW #140 and #141 speaking in a loud voice: "smell it, smell your shit" to the resident, and the resident was crying. The incident was reported to the home on a later date.

Interview with resident #014 confirmed he/she witnessed the above mentioned incident and the resident was crying and upset.

Interview with the ED confirmed the above mentioned incident was reported to the home and PSW #140 and #141 had received disciplinary action as a result of the incident.

The home has failed to protect resident #013 from emotional and verbal abuse by staff members on July 21, 2015. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) 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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A review of resident #006's progress notes revealed RD's referral response recommended the resident to receive the specified supplements for altered skin integrity on an identified date.

Record review of resident's physician's orders indicated RD's recommendation was not ordered until 41 days later. Further review of resident's medication administration record (MAR) revealed the specified supplements were not administered until the date it was ordered.

Interview with RN #133 revealed the home's practice is to notify the physician immediately regarding any recommendations from the RD and was unsure why the recommendation was not initiated as mentioned above.

Interview with the DOC confirmed that the physician should have been notified immediately of the recommendations from the RD and the resident did not receive immediate interventions as required. [s. 50. (2) (b) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach and those actions were taken and outcomes were evaluated:
- A change of 5 per cent of body weight, or more, over one month.
- Any other weight change that compromises the resident's health status.

A review of resident #011's weight record revealed that the resident had more than 5 per cent weight loss in an identified one-month period.

A review of resident #011's progress notes and assessment records indicated it had no record of assessment for resident's weight loss in the identified one-month period.

Interview with the FSS confirmed that the dietary department did not receive a referral from the nursing department for resident's significant weight change the identified one-month period. Therefore, there was no communication with the RD for resident's weight change, and the FSS and DDS did not review or assess resident's weight loss.

Interview with the RD and RPN #110 confirmed that there was no referral sent to the RD for resident's weight loss in the identified one-month period, and the RD did not complete the assessment. The resident's weight loss was not assessed using an interdisciplinary approach. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach and those actions are taken and outcomes are evaluated:
- A change of 5 per cent of body weight, or more, over one month.
- Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

a. Record review of resident #005's RAI-MDS assessment indicated the resident has a specified medical condition. Further review of the resident's records revealed the care plan goals and interventions have been reviewed by the care team members and continue to be effective in preventing, improving or maintaining this actual problem.

Record review of resident #005's plan of care dated an identified date revealed resident's specified medical condition was not included. Interviews with RPN #131 and DOC confirmed that the resident has the specified medical condition and the plan of care was not updated to reflect this.

b. A review of resident #007's RAI-MDS assessment indicated resident's specified medical condition. Further review of resident's plan of care dated an identified date revealed the plan of care was not updated to reflect the resident's specified medical condition.

Interview with RPN #131 revealed that the resident was identified with the specified medical condition and the plan of care was not updated.

Interview with the DOC confirmed that the plan of care for resident #007 should set out the planned care for resident’s specified medical condition and it was not. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A review of resident's #006's progress notes and pain assessments revealed the resident has pain due to a specified medical condition on multiple body areas. Further review of resident #006’s plan of care directed staff to administer a specified drug to resident prior to a specified treatment procedure. A review of the MAR indicated the specified drug was administered one hour prior to the specified treatment procedure and scheduled PRN or as needed.

Interviews with RPN #124 and RN #133 revealed the resident has pain during the specified treatment procedure and the plan of care directs staff to administer the specified drug one hour prior to the specified treatment procedure and not as a PRN or as needed.

Interview with the DOC confirmed the resident did not receive the specified drug one hour prior to the specified treatment procedure because the plan of care did not provide clear directions to staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date, the home submitted a critical incident report to the Director, reporting assertions made by resident #024 and his/her identified family member that, former PSW #143 transferred the resident on his/her own on either of two identified dates. The identified family member of resident #143 also reported to the home that he/she had witnessed PSW #143 yelling at the resident and handling the resident in a rough manner on an identified occasion.

The written plan of care for former resident #024 stated that the resident required a specified assistive device for all transfers and extensive assistance of two staff.

A review of the home's internal investigation report revealed that PSW #143 was disciplined related to transferring the resident not in accordance to the written plan of care. Interviews held with resident #024's identified family member and PSW #145 provided conflicting information. The identified family member of the resident indicated observing PSW #143 transferring resident #024 on various occasions without the assistance of another staff member. PSW #145 indicated that he/she had assisted PSW #143 on occasions with transferring the resident however, could not recall the date in question. Interviews held with the ED, DOC and corporate confirmed that the care set out in the plan of care related to resident #024's transferring requirement was not provided as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the plan of care was revised at any time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of resident #003's progress notes revealed on an identified date, the resident fell at night by his/her bed. The fall was unwitnessed and the resident sustained no injury. Further review of the progress notes indicated three days later, staff member suggested a specified intervention for resident's safety. It did not indicate when it would be implemented. A review of the resident's plan of care indicated it did not mention the specified intervention for the resident.

Interviews with PSW #105, RN #129 and NM #130 indicated the specified intervention was given to the resident for safety after the fall. RN #129 and NM #130 indicated the resident's current condition had improved and the specified intervention was no longer necessary for the resident, and they did not remember when it was started and discontinued.

Interviews with RN #129 and NM #130 confirmed the plan of care was not revised when the resident's care needs for safety changed in relation to the specified intervention for the resident. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a. The home's policy entitled "Inventory Management- Drug Disposal" (Index #05-02-20, last reviewed October 1, 2012) states the following:
The following medications will be identified, destroyed and disposed of including:
- Expired medications.
- Medications with illegible labels.
- Medications that are not labeled appropriately as per labeling standards.
- Medications that are no longer required due to being discontinued, or when a resident is discharged or deceased.

On the 19th day of an identified month, the inspector observed a specified drug contained within the government stock medication cupboard with an expiry date labeled the month before.

Interviews held with the NM #103, ADOC, DOC and ED confirmed that all expired drugs are to be disposed of and the policy was not complied with.

b. The home's policy entitled “Continence Care Program- Guidelines for Care” (Policy #VII-D-10.00, last revised January 2015) directs Registered staff to conduct an assessment of the resident's bladder and bowel functioning upon admission, annually, and when there is a significant change in condition that impacts bladder and bowel functioning.

Resident #008 had a specified medical condition and required staff to assist in managing his/her specified medical condition. Review of the health record revealed and interviews held with NM #103, #128, RN #106, ADOC and DOC confirmed that the last required annual assessment was conducted on an identified date in 2014, and did not have the required annual assessment conducted in 2015 which did not comply with the home's policy. [s. 8. (1) (b)]

2. A review of the home’s policy entitled “Height Measurement” (Policy #VII-G-20.90, revised October 2015) indicated that all resident’s height will be taken and recorded within 48 hours of admission and then taken annually and whenever there is a significant change in height.

A review of resident #008, #010, and #011’s height record revealed that height was not recorded in an identified year.

Interview with RN #106, RPN #110, and RD confirmed that the home’s policy is to measure and record all resident’s height on admission and annually then after. They also confirmed that above mentioned resident’s height should have been taken in the identified year. [s. 8. (1) (b)]

3. A review of the home’s policy titled “Skin and Wound Care Management Protocol” (Policy #V11-G-10.80, revised July 2015) indicated registered staff will document, in the individualized plan of care any skin care measures to identify level of risk, promote healing, optimize nutrient intake, minimize pain and discomfort, and prevent deterioration and infection.

Record review of resident #006's weekly wound and skin assessment, indicated a specified intervention to the resident's specified medical condition. Further review of resident's plan of care indicated the plan of care was not updated to reflect this intervention.

Interview with RPN #124 revealed the plan of care is updated whenever there is a change in the plan of care.

Interview with the DOC confirmed staff did not update the care plan and did not follow the policy as mentioned above. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

On an identified date, the inspector observed DDS was pouring fluids in an identified servery without wearing a hairnet.

A review of the home's policy entitled "Uniform Dress Code (HACCP)" (Policy #E004, revised January 2014) indicated to wear the approved hair restraint (covering hair entirely) when on duty.

Interview with DA #120 and FSS indicated that the hairnet is required for anyone who is working in the servery. FSS indicated food service management does not allow non-dietary staff to enter the dietary areas and all areas are secured all the time.

Interview with DDS revealed that anyone who is serving food has to wear a hairnet.

Interview with RD confirmed that DDS should have worn the hairnet while serving fluids in the servery to prevent any kind of adulteration and contamination. [s. 72. (3) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: proper techniques to assist residents with eating, who required assistance.

On an identified date, in a specified home area, the inspector observed PSW #113 used a fork to feed resident #044.

A review of the RAI-MDS assessment and Resident Assessment Protocol (RAP) indicated that the resident required specified staff assistance for eating.

A review of resident #044's plan of care revealed that the resident required the specified staff assistance for eating related to a specified medical condition.

Interview with PSW #113 confirmed that he/she should have used a teaspoon instead of a fork to assist the resident for eating, and using a fork is not the safe feeding technique.

Interview with RPN #115, RN #106, FSS, and the DOC confirmed that staff are required to use teaspoon all the time while assisting residents with eating.

Interview with RD confirmed that assisting the resident using a fork is not a safe feeding technique unless it is indicated in the resident's plan of care. [s. 73. (1) 10.]

2. The licensee has failed to ensure that, no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

On an identified date, in a specified home area, the inspector observed that soup was served to resident #041, #042, and #043 without feeding assistance available. Main course was served to resident #043 without feeding assistance available.

A review of resident #041, #042, and #043's plan of care indicated that they required specified staff assistance for eating.

A review of the home's policy entitled "Meal Service in the Dining Room" (Policy #C008, revised January 2014) indicated that residents who requires assistance with eating or drinking are not served his or her meal until someone is available to provide assistance.

Interviews with PSW #101 and #114, RPN #115, DDS, FSS, and RD confirmed that food

should not be served to residents unless feeding assistance is available to residents. [s. 73. (2) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

On an identified date, the inspector observed the home's policy to promote zero tolerance of abuse and neglect of residents was not posted.

Interviews with ADOC and unit scheduling clerk confirmed a copy of the home's policy entitled "Prevention of Abuse and Neglect of a Resident" (Policy #VII-G-10.00, revised January 2015) is usually posted on the information board by the reception desk and confirmed the policy was not there. [s. 79. (3) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review revealed and an interview with the DOC confirmed that the interdisciplinary team which conducted the annual evaluation of the medication management system for 2014 did not include the Medical Director, Administrator, pharmacy service provider and Registered Dietitian, as required.

Further interview with the ED confirmed that the annual evaluation is conducted by the registered staff and charge nurses who will then share the results at the professional advisory committee with the pharmacy provider and the Medical Director. [s. 116. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team documented the names of the persons who destroyed the drug in the drug record.

A review of the home's policy entitled "Inventory Management- Drug Disposal" (revised July 25, 2014) revealed that the written policy does not indicate that the name(s) of the person(s) who destroyed the drug is to be documented on the drug record.

An interview held with the DOC confirmed that this is currently included in the procedure for disposing of drugs and should be included in the home's written policy. [s. 136. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

On an identified date, in specified home area, the inspector observed PSW #114 did not perform hand hygiene after clearing soiled soup bowls and prior to pouring milk for the resident. PSW #101 did not perform hand hygiene after clearing soiled dishes and prior to touching and encouraging three residents for eating.

Interviews with PSW #114 and #101 confirmed that they should have performed hand hygiene after clearing soiled utensils and prior to their next tasks in the dining room.

Interviews with the DDS, RD, RPN #115, and DOC confirmed that the above mentioned staff should perform hand hygiene during dining services in between tasks. [s. 229. (4)]

Issued on this 11th day of February, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.