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

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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
Jan 28, 2015	2014_378116_0019	T-094-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. CLAIR O'CONNOR COMMUNITY INC
2701 St Clair Avenue East East York ON M4B 3M3

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

ST. CLAIR O'CONNOR COMMUNITY NURSING HOME
2701 St Clair Avenue East East York ON M4B 3M3

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

SARAN DANIEL-DODD (116), GORDANA KRSTEVSKA (600), SUSAN SEMEREDY (501)

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): December 18, 22, 23, 24, 29, 30, 31, 2014 and January 5, 6, 2015.

Log #T-003508-14 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), assistant director of care (ADOC), resident assessment instrument minimum data set (RAI-MDS)coordinator, food services supervisor, registered dietitian, recreation and programs manager, maintenance manager, Presidents of Residents' and Family Council, registered staff members, personal support workers (PSW), housekeeper, janitor, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **5 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #001 is identified at high risk for falls related to memory loss and reduced mobility. On an identified date, the resident experienced an unwitnessed fall in his/her room.

An interview held with the assistant director of care (ADOC) revealed that the home implemented the post fall assessment tool in late July 2014. As per the home's falls prevention policy (policy # NUR-XVI-073-A), registered staff are required to complete an incident report and post fall screening tool after every incident of falls.

Interviews held with a registered staff member and the ADOC confirmed that an incident report and post fall assessment were not completed after resident #001 fell. [s. 49. (2)]

2. Resident #006 is identified at high risk for falls related to unsteady gait, memory loss and medication therapy. Resident #006 has experienced multiple unwitnessed falls over an identified two-month period.

Interviews held with a registered staff member and the ADOC confirmed that post fall assessments were not completed after each incident of falls for resident #006. Furthermore, post fall assessments were not conducted for any incidence of falls for residents prior to August 2014. [s. 49. (2)]

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 when the resident has fallen, the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a system to monitor and evaluate fluid intake of residents with identified risks related to hydration.

Record review revealed that resident #002 is on a mechanical, thickened fluid diet. The home's policy #DTY-XI-020 titled "Hydration Management" states that one of the factors that puts residents at risk for dehydration is when residents are on a pureed foods and/or thickened fluids diet. Review of intake documentation over an identified two-month period, indicates resident #002 consumed less than 500 millilitres of fluid on 24 out of 59 days. Interview with a registered staff member revealed that fluid intake of less than 1500 millilitres would be insufficient however, there is no daily monitoring of individual fluid intakes. Interview with the food service manager (FSM) and ADOC confirmed the home would work towards creating a system to monitor and evaluate fluid intakes. [s. 68. (2) (d)]

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 there is a system to monitor and evaluate fluid intake of residents with identified risks related to hydration, to be implemented voluntarily.

WN #3: 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).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids are served using methods which prevent contamination.
On a specified date, the inspector observed during the lunch meal service, that staff were scraping food from dirty plates and trays from resident rooms into a bucket on a cart which was placed at the same level and approximately 30 centimetres from the steam table which was holding food that was still being served. Interviews with registered staff and the RD revealed that scraping dirty plates so close to the steam table could contaminate the food. Interview with the FSM confirmed that this set up was not ideal and the home is looking into a different system to dispose of unused food items. [s. 72. (3) (b)]

2. The licensee has failed to ensure that staff comply with the cleaning schedule for all the equipment related to the food production system.
On a specified date, the inspector observed many dirty items in the kitchen which included (and may not be limited to):
• steam table
• freezers
• stove top
• steamer
• knife holder and knives inside holder
• trolley in walk in fridge.
Interview with the FSM confirmed that these areas were not clean and that staff have not been complying with the cleaning schedule. [s. 72. (7) (b)]

3. The licensee has failed to ensure that there is a cleaning schedule for the servery areas.
On a specified date, the inspector observed many dirty areas in a identified servery area which included (and may not be limited to):
• microwave
• cart
• dirty side of steam table where waste containers are situated
Interview with the FSM confirmed that there is no cleaning schedule for the servery area. [s. 72. (7) (c)]

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 all food and fluids are served using methods which prevent contamination, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On an identified date, during a scheduled medication pass, the inspector observed the narcotic cupboard stored within the medication cart to be unlocked. Upon examination by the assigned registered staff member the narcotic bin was unable to be locked and brought to the attention of the ADOC. Interviews held with a registered staff member and the ADOC confirmed that the narcotic cupboard is to be double-locked at all times within the medication cart. [s. 129. (1) (b)]

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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #5: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a designated staff member who co-ordinates the infection prevention and control program has education and experience in infection prevention and control practices including, infectious diseases, cleaning and disinfection, data collection, trend analysis, reporting protocols and outbreak management.

Record review revealed and staff interview confirmed that the designated staff member who co-ordinates the infection prevention and control program has no education and experience in the above mentioned infection prevention and control practices. [s. 229. (3)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.
On an identified date, the home was declared to be in a respiratory outbreak. On an identified date, the inspector observed during a meal service, an identified PSW to return to the dining room holding a tray from a resident's room. The PSW was not observed to wash or sanitize his/her hands before preparing another tray. The food items on the tray were not covered and taken to another resident room. Interview with this PSW revealed he/she was aware that he/she should have covered the items with plastic wrap in order to prevent the spread of infection.
Interview with the ADOC and executive director (ED) confirmed that staff should wash their hands between disposing of dirty trays and preparing of new trays and that items being transported down the hallways should be covered. [s. 229. (4)]

3. Over a two-day period during a declared respiratory outbreak, the inspector observed two masks discarded in a garbage bin stored in the hallway/lounge area were not removed. Interview held with the ADOC confirmed that the garbage is to be removed on a daily basis.
On January 2, 2015 at 4:00 p.m., a registered staff member was observed exiting a resident room that is under isolation with mask and gloves. The registered staff member went across the hallway to a medication cart and removed the gloves and mask. An interview with the registered staff member confirmed that he/she did not follow the home's infection prevention and control practice regarding isolation. [s. 229. (4)]

4. The licensee has failed to ensure that the information that was gathered on every shift about the residents' infections, was analyzed daily to detect the presence of infection and was reviewed at least monthly to detect trends for the purpose of reducing the incidence

of infections and outbreaks.

Staff interview indicated and record review confirmed that there was no evidence if the information that was gathered on every shift about the residents' infections, was reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks. [s. 229. (6)]

5. The licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
Staff interview indicated and record review of randomly chosen residents confirmed that residents were not offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #001 was identified at high risk for falls related to memory loss and reduced mobility.

Interviews held with registered staff members and PSWs provided conflicting information regarding current interventions in place to reduce the risk for falls for resident #001. A registered staff member indicated that the bed is to be kept at the lowest position, quarter side rails are to be engaged while in bed and the room is to be kept free of clutter. An identified PSW was not aware of the interventions in place.
Review of the health record and interviews held with registered staff and PSWs confirmed that the written plan of care does not set out any directions to staff and others who provide direct care to the resident with regards to fall interventions. [s. 6. (1) (c)]

2. Resident #006 is identified at high risk for falls related to unsteady gait, memory loss

and medication therapy.

Interviews held with registered staff members and PSWs provided conflicting information regarding current interventions in place to reduce the risk for falls for resident #006. A registered staff member indicated that the bed is to be kept at the lowest position, quarter side rails are to be engaged while in bed, monitored hourly and the room is to be kept free of clutter. An identified PSW was not aware of the interventions in place.
Review of the health record and interviews held with registered staff and PSWs confirmed that the written plan of care does not set out any directions to staff and others who provide direct care to the resident with regards to fall interventions. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other.

Record review revealed that resident #002 had a decrease of 2.8 kg over a one-month period, representing a 5.2 per cent weight loss in one month and that the resident is to receive a specified evening snack. Review of intake documentation over a specified period, indicates that resident #002 never consumes this special snack. Staff interviews revealed that nursing staff have not been reporting this refusal and confirmed that they have not collaborated with the dietary department in the development and implementation of the plan of care so that the different aspects are integrated, consistent and complement each other. [s. 6. (4) (a)]

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

On an identified date, the inspector observed resident #003 was served an identified mechanical diet in his/her room which consisted of minced pasta and minced salad. Record review revealed that resident #003 is to receive a specified mechanical diet according to the plan of care. Interview with an identified PSW and dietary aide confirmed that resident #003 did not receive the correct mechanical diet. [s. 6. (7)]

5. Resident #011 is identified at high risks for falls due to a history of falls, confusion, poor vision and unable to follow directions. The written plan of care documents that resident #011 is not to be left alone during toiletting.

On an identified date, resident #011 was taken to the toilet and left alone for an unspecified amount of time, enough for the resident to fall and sustain an injury that required the resident to be transferred to the hospital for further assessment.
Record review revealed and an interview with the ADOC confirmed that the staff did not provide the care to the resident as specified in the plan. [s. 6. (7)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered at each meal.
On an identified date, the inspector observed resident #002 was served a mechanical diet for a scheduled meal and the resident consumed all of these items. Record review revealed that mechanically altered bread should be offered with this meal and that resident #002 has recently had significant weight loss. Interview with an identified dietary aide revealed that they only serve the bread if someone asks for it. Interview with the FSM confirmed that mechanically altered bread should have been offered to resident #002. [s. 71. (4)]

WN #8: 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: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the daily and weekly menus are communicated to residents.
On an identified date, the inspector observed during a scheduled meal service, that the daily menu for the scheduled meal was missing from the menu board and the weekly menu had not been changed to the appropriate week. Interview with an identified dietary aide revealed he/she had taken the menu to the servery bulletin board so he/she would know what to serve the residents. Interview with the FSM confirmed that the daily and weekly menu should have been available for the residents. [s. 73. (1) 1.]

2. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

On an identified date during the inspection, the inspector observed during a scheduled meal service, that an identified PSW was assisting more than two residents with eating and drinking. Interview with the registered dietitian (RD) revealed that this occurred because due to the outbreak, the home was short staffed. Interview with the FSM confirmed that only one or two residents should be assisted at the same time who need total assistance with eating or drinking. [s. 73. (2) (a)]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Upon the initial walk-through of the home, the following required information for the purposes of subsection (1) and (2) were not posted:
- the Resident's Bill of Rights;
- 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;
- copies of the inspection reports from the past two years for the long-term care home.

An interview held with the ADOC and recreation manager confirmed that the required information was stored away during home renovations and not re-posted as required. [s. 79. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols are reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director.

Review of the written policies and interview with the ADOC confirmed that the policies of the medication management system are solely developed and approved by the licensee's pharmacy service provider. [s. 114. (3) (b)]

WN #11: 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, meets 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 and interviews held with the ED and the ADOC confirmed that the medication management system is not evaluated on an annual basis. [s. 116. (1)]

WN #12: 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. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's drug destruction and disposal policy include that drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The home utilizes GeriatRx Pharmacy policies and procedures for the medication management system. A review of GeriatRx Pharmacy policy #3.14 entitled "Disposal of Surplus Medications" identified that the policy does not outline all of the requirements stipulated for a drug destruction and disposal policy. [s. 136. (2) 1.]

2. The licensee has failed to ensure that the home's drug destruction and disposal policy include that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The home utilizes GeriatRx Pharmacy policies and procedures for the medication management system. A review of Geriatrx Pharmacy policy #3.14 entitled "Disposal of Surplus Medications" identified that the policy does not outline all of the requirements stipulated for a drug destruction and disposal of controlled substances. [s. 136. (2) 2.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package includes information on the ability to retain a physician or RN (EC) to perform the required services.

Review of the admission process checklist completed by the ED during the inspection and interview with the ED confirmed that the admission package does not include information on the ability to retain a physician or RN (EC) to perform the required services. [s. 224. (1) 1.]

Issued on this 2nd day of February, 2015

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

Original report signed by the inspector.