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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 3, 2019	2019_555506_0002	007062-18, 020444-18, 022869-18, 027741-18, 031225-18, 031229-18, 001016-19, 009042-19	Critical Incident System

Licensee/Titulaire de permis

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 15, 16, 17, 22, 23 and 24, 2019.

The following intakes were completed concurrently with the Critical Incident Inspection.

Follow-up Inspections:

log # 031225-18- related to medication administration
log # 031229-18- related to abuse and neglect

Critical Incident Inspections:

log # 007062-18- related to abuse and neglect
log # 020444-18- related to abuse and neglect
log # 022869-18- related to medication management
log # 027741-18- related to medication management
log # 001016-19- related to medication administration
log # 009042-19- related to abuse and neglect

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support Ontario staff, residents and families.

During the course of the inspection, the Inspector(s) toured the home, completed observations of the provision of care, medication administration, reviewed resident clinical records, the homes policies and procedures, the homes investigation notes and staff training records.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

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

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #008	2018_720130_0010	506
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #006	2018_720130_0010	506

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	Légende 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

Ontario Regulation 79/10 s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

A. Specifically, staff did not comply with the licensee's policy "Disposal for Monitored Medications", section 6, (dated July 2017) as part of the medication management to allow for safe and secure disposal of monitored Narcotic and Controlled medication and to ensure drugs are disposed of properly.

A Critical Incident Report C501-000003-19 was submitted to the Director on an identified date in January 2019, regarding a missing controlled substance for resident #114 on an identified date in December 2018. On an identified date in January 2019, the home was completing their routine drug destruction and disposal with the pharmacist at the home and discovered that there were missing controlled substances as the controlled substances were not on the disposal record sheet or in the locked destruction bin. Resident #014 had an order for the controlled substance. The medication administration record confirmed that the medications were administered by staff #121 on an identified date in December 2018. The home's investigation notes confirmed that the staff confirmed through an interview that they threw out the controlled substance in the garbage. Interview with the ADOC on an identified date in May 2019, confirmed that the licensee did not follow their policy and procedure to allow for safe and secure disposal of monitored Narcotic and Controlled medications.

B. Specifically, staff did not comply with the licensee's policy "Combined Individual Monitored Medication Record with Shift Count", section 6, (revised January 2018) as part of the medication management to track monitored medication and that two staff are to sign at the time of administration if a monitored drug is wasted.

A Critical Incident Report C501-000026-18 was submitted to the Director on an identified date in August 2018, regarding controlled substances not being wasted according to the licensee's policy. Resident #006 had an order for a controlled substance and was

reported by RN #116 that staff were not having the remainder of the medication wasted on four dates in July 2018. A review of the home's investigation notes confirmed that there were 14 days in June and July, 2018, that the resident's medication was not wasted as per the licensee's policy. Interview with the ADOC on an identified date in May 2019, confirmed that the licensee did not follow their policy and procedure for Combined Individual Monitored Medication Record with Shift Count where two staff were to sign at the time of administration when a monitored drug was wasted. [s. 8. (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 written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

A Critical Incident Report C501-000031-19 was submitted to the Director on an identified date in May 2019, informing the Director of an alleged incident of verbal and physical abuse to resident #010 by PSW #120. A review of the investigation notes provided by the home and interviews conducted confirmed that the licensee did not notify the appropriate police force. Interview with the DOC on an identified date in May 2019, confirmed that the police were not notified immediately or at the time of this inspection of the alleged verbal and physical abuse to resident #010 by PSW #120. [s. 98.]

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 the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004's Substitute Decision Maker (SDM) was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

On an identified date in August 2018, a Behavioural Support of Ontario (BSO) worker reported an incident they witnessed between PSW #103 and resident #004 on an identified date in August 2018, to the Chief Nursing Officer. A review Critical Incident Report C501-000027-18 that was submitted to the Director and a review of the resident's clinical record did not include documentation that resident #004's SDM was notified of the incident that took place on an identified date in August 2018. Interview with the DOC on an identified date in May 2019, confirmed that the resident's SDM was not notified of the incident that was witnessed on an identified date in August 2018. [s. 97. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A Critical Incident Report C501-000035-18 was submitted to the Director on an identified date in October 2018, regarding a missing controlled substance. On an identified date in October 2018, RPN #104 went to check on the application of the medication and to ensure it was being administered. RPN #104 confirmed in an interview with the Inspector on an identified date in May 2019, that they went and rechecked with RPN #106 who verified they applied the medication the previous evening. After an investigation into the incident the licensee could not determine how long the resident was without their prescribed medication. On an identified date in May 2019, the ADOC confirmed that the resident did not receive the required dose of the medication, as the medication was not administered to the resident in accordance with the directions for use specified by the physician.

A compliance order was issued regarding medication administration after this incident occurred on inspection report #2018_720130_0010, log #003146-18. [s. 131. (2)]

Issued on this 7th day of June, 2019

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

Original report signed by the inspector.