Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 3, 2010	2010_146_8501_02Nov082844	Critical incident H-02102

Licensee/Titulaire

Albright Gardens Home Incorporated, 5050 Hillside Drive, Beamsville, ON, L0R1B2

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

Albright Gardens Home Incorporated, 5050 Hillside Drive, Beamsville, ON, L0R1B2

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

Barbara Naykalyk-Hunt, #146

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical incident inspection related to misappropriated controlled substance.

During the course of the inspection, the inspector spoke with: the Chief Executive Officer (CEO), the Director of Nursing and Personal Care (DOC), a receptionist and an administrative assistant

During the course of the inspection, the inspector: toured and observed the fourth floor unit including the medication room and locked medication destruction cupboard.

The following Inspection Protocols were used in part or in whole during this inspection: Medications

☒ Findings of Non-Compliance were found during this inspection. The following action was taken: 2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with: O.Reg. 70/10, s.129(1)

129 (1) Every licensee of a long-term care home shall ensure that,
(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.

Findings:

1. As reported by the Director of Nursing and Personal Care (DOC), in September 2009, a controlled substance, hydromorphone ampoules, labeled with the name of a resident who no longer required the medication, was placed by the medication nurse in an unlocked and accessible area of the home (a bag or sack) for pharmacy pick-up, instead of, as policy directed, in the double locked stationary cupboard for disposal. The resident-labeled controlled substance was later found in August 2010 in the community. This practice of returning newly received unopened narcotics to the pharmacy in an unlocked and accessible sack was a fairly routine habit unknown to the management of the home. The practice was stopped upon discovery by the DOC in early September 2010.

WN #2: The Licensee has failed to comply with : O.Reg. 79/10, s.107(3)
107.(3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance.

Findings:
1. The home became aware of the misappropriated controlled substance, the hydromorphone ampoules, in August 2010 and had the information confirmed by police in early September 2010. The Critical Incident was sent to the Ministry October 15, 2010 at 1034.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).