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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 12, 2016	2016_248214_0011	017739-16	Critical Incident System

Licensee/Titulaire de permis

ALBRIGHT GARDENS HOMES INC.
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

CATHY FEDIASH (214)

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): June 15 and 23, 2016.

Please note: The following inspections were conducted simultaneously with this Critical Incident System inspection:

-Complaint logs: 007035-16; 013440-16; 016839-16; 018719-16 related to RN staffing.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO); Chief Nursing Officer (CNO); Resident Assessment Instrument (RAI) Coordinator; registered staff; Medical Doctor (MD) and residents. During the course of this inspection the inspector observed the administration of medications; reviewed resident health records; reviewed the home's investigative notes and reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication

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)**

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one Registered Nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A review of a Critical Incident System (CIS) submitted by the home indicated that on an identified date in 2016, resident #100 was administered drugs that had not been prescribed for them and as a result, sustained a change in their health status requiring a transfer to hospital the following day.

A review of the Registered Staffing Schedule for an identified period of time in 2016, indicated that a Registered Nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home for the following shifts: part of the night shift on March 1, 2016; full night shift on April 18, 2016; part of the day shift on May 15, 2016; full evening shift on May 16, 2016; full night shift on May 23, 2016; part of the night shift on May 28 and 29, 2016; part of the night shift on May 30, 2016; full night shift of June 7, 2016; and at the time of the medication incident on the evening shift of June 8, 2016.

An interview with the CNO confirmed that the home did not have an RN for these regular scheduled shifts and where possible, the shifts were replaced by a Registered Practical Nurse (RPN). The CEO and the CNO confirmed the home had been unsuccessful in recruiting Registered Nurses despite their efforts.

PLEASE NOTE: The above noted non-compliance was identified while conducting concurrent Complaint inspection Log #'s 007035-16; 013440-16; 016839-16; 018719-16. [s. 8. (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 at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for them.

A review of a CIS submitted by the home indicated that on an identified date in 2016, resident #100 was administered drugs that had not been prescribed for them. A review of the CIS and the resident's progress notes indicated that the resident was administered a total of six identified medications and as a result, sustained a change in their health status requiring a transfer to the hospital the following day.

An interview with the CNO confirmed that resident #100 was administered drugs that had not been prescribed for them. [s. 131. (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 that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: 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 failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

1. A review of the home's pharmacy policy titled, The Medication Pass (3-6 and dated January 2014) indicated the following under procedure:

i) Identify resident using two identifiers, such as photo armband or other staff, never by verbal response.
ii) Ensure resident is ready to take medications.
iii) Find MAR (Medication Administration Record) for the resident and identify medications for the pass time.
iv) Locate medications for the resident.
v) Check each medication label against MAR to ensure accuracy.

A review of a CIS submitted by the home indicated that on an identified date in 2016, resident #100 was administered drugs that had not been prescribed for them and as a result, sustained a change in their health status requiring a transfer to hospital the following day.

A review of the home's investigative notes indicated that on an identified date in 2016, registered staff #003 had received the resident in their bed; called out the resident's first name and indicated that they had their medications. Staff #003 administered the medications to the resident. The resident had indicated that they did not normally take medication. The registered staff member checked the Electronic Medication Administration Record (EMAR) and realized that the medications administered had been for the wrong resident. The registered staff member obtained a clean cloth to wipe out

the resident’s mouth; however, the medications had already been swallowed.

An interview with the CNO confirmed that staff #003 had not used two identifiers as indicated in the home's policy and had used a verbal response to identify the resident. The CNO confirmed that the home's policy had not been complied with as two appropriate identifiers had not been used and the registered staff member had not ensured that the resident was ready to take their medications prior to dispensing the medications.

2. A review of the home’s policy titled, Medication Incident Reporting (9-1 and dated February 2016) indicated the following under procedure:

i) Complete the Medical Pharmacies "Medication Incident Report" online when a medication incident or adverse drug reaction has occurred including a near miss.

OR

ii) Call the number listed to verbally complete the "Medication Incident Report". Ensure you have all the details prior to calling. The Service Centre representative will ask questions to document the incident details which will help in the causal analysis of the incident. A copy is available by fax back and emailed to the home and pharmacy management. Fax a completed "Medication Incident Form" to the Service Centre at the number listed on the policy. An email report is sent to the home and pharmacy management.

A review of a CIS submitted by the home indicated that on an identified date in 2016, resident #100 was administered drugs that had not been prescribed for them and as a result, sustained a change in their health status requiring a transfer to hospital the following day.

An interview with the CNO confirmed that on the date of the medication incident, staff had started the online medication incident report when the computer screen froze and the report was unable to be completed. The staff completed a paper medication incident report in place of the online report; however, had not faxed the report to the pharmacy and as a result, the pharmacy had been unaware of this incident. The CNO confirmed that the home’s pharmacy policy had not been complied with. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

A review of the home's medication incidents for an identified period of three months in 2016, was conducted. An interview with the CNO indicated that during this time frame there had been a total of 19 medication related incidents. The CNO confirmed that a quarterly review of these medication incidents had not been undertaken. [s. 135. (3)]

Issued on this 12th day of July, 2016

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

Original report signed by the inspector.