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 5, 2016	2016_226192_0004	032778-15, 034283 - 15	Complaint

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 5, 6, 7, 8, 11, 12, 13 and 14, 2016

This complaint inspection related to Intakes 032778-15 and 034283-15 were conducted concurrently with Resident Quality Inspection 035820-15.

During the course of the inspection, the inspector(s) spoke with the Vice President of Clinical Services, Executive Director, Director of Resident Care, Registered Practical Nurses, Personal Support Workers, the Residents and Substitute Decision Maker.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

Resident #001 had a specified medication ordered by the physician. The medication was accessed by a staff member from the Emergency Supply Box.

Review of the Medication Administration Record (MAR) confirmed that the resident was provided with medication.

Interview with the Substitute Decision Maker for resident #001 identified that on specified dates resident #001 received one tablet and on the fifth date, the nurse providing the medication gave the resident two tablets.

A medication error was reported by phone to the pharmacy.

Interview with the Vice President of Clinical Services confirmed that it would be the expectation that each medication incident would be investigated, a root cause of the incident identified and staff involved would be interviewed. Other actions such as retraining would be completed, as determined by the investigation.

The Director of Resident Care was asked to provide documentation to support the investigation into the medication error involving resident #001 and actions taken as a result of that investigation. No documentation was provided.

The licensee failed to ensure that all medication incidents were documented, reviewed and analyzed, corrective action was taken as necessary and a written record was kept of the review, analysis and corrective action taken. [s. 135. (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 ensuring that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

Issued on this 5th day of February, 2016

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

Original report signed by the inspector.