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
Jun 17, 2015	2015_322156_0009	H-002403-15	Resident Quality Inspection

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

CAROL POLCZ (156), IRENE SCHMIDT (510a), KELLY CHUCKRY (611), LESLEY EDWARDS (506), ROBIN MACKIE (511)

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): May 25 - June 8, 2015

Inspections which were completed simultaneously include: critical Incidents: H-002019-15, H-001571-15, H-002352-15, H-002310-15, H-002370-15, H-002579-15, H-002201-15 and complaints H-002576-15, H-002106-15, H-002079-15

During the course of the inspection, the inspector(s) spoke with Administrator, Chief Nursing Officer (CNO), Director of Care (DOC), Food Services Manager (FSM), dieatary staff, Registered Dietitian (RD), registered nursing staff, personal support workers (PSW's), Laundry Manager

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

10 WN(s)
4 VPC(s)
1 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

In November, 2014 resident #602 exhibited responsive behaviours towards an identified Personal Support Worker (PSW). In response to this, the PSW called resident #602 a name. Resident #602 reported the incident to another identified PSW.
The Chief Nursing Officer (CNO) confirmed that the incident occurred and the staff member in question was disciplined as a result of the incident.
The PSW did not respond in a way that fully recognized resident #602's individuality and did not respect the residents dignity. [s. 3. (1) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The care plan located in a binder on the floor that was used to direct front line staff as well as the computerized copy on point click care for resident #004 indicated that staff were to apply a front fastening seat belt when the resident was in the wheelchair for safety (positioning). Staff were directed to release and reapply the restraint every two hours and reposition the resident and document the response hourly. Front line staff

confirmed that the binders were the updated copies of the care plans and were used to direct front line staff.
During stage one of the inspection, resident #004 was observed with the wheel chair seat belt fastened and was not able to undo it when requested to do so by the inspector.
On June 3, 2015 the resident was observed in the wheel chair in the dining room with tape across the wheel chair seat belt that indicated "Do not use".
The RN reported on June 3, 2015 that the seat belt had been discontinued; progress notes indicated a two week trial had been initiated to remove the restraint as the resident no longer moved in the wheel chair. Current physicians orders did not include a seat belt restraint.
The plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #013 was observed with a seat belt on during stage one of the inspection. The resident was able to apply and remove the seat belt and reported that they preferred to have the seat belt on. The resident was again observed on June 3, 2015 with the seat belt on and reported that they preferred it to be on. A review of the residents' plan of care did not include the resident's preference or assessment of the seat belt. Interview with the CNO on June 3, 2015 confirmed that the seat belt should be part of the resident's plan of care. [s. 6. (2)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

The current care plan for resident #300 indicated that the resident was totally dependent on others for eating.
The resident was observed in the dining room on June 3, 2015 receiving total assistance in eating.
The MDS quarterly assessment dated September, 2014 under eating, the assessment indicated 3, that the resident required extensive assistance with this task. The next two quarterly assessments under the same section, indicated, that the resident required limited assistance with the task of eating and was highly involved in the activity.
Interview with the registered nursing staff on June 3, 2015 reported that this was an error, the resident had not improved in their ADL's and that the assessment was

incorrect.
The licensee did not ensure that the assessments of the resident were integrated, consistent with and complement each other. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

A review of the plan of care for resident #401 indicated the resident had a history of falls and had been considered a moderate risk for falls. The resident sustained a fall in February, 2015 that resulted in an injury that required surgery in February, 2015. A review of the physician orders in April, 2015 indicated the MD requested physiotherapy (PT) to assess the resident for rehabilitation in follow-up from their surgery. Two referrals were identified in the progress notes from the registered staff to the PT to 1. assess as requested by the MD and 2. at the request of the family to assess if the resident would be able to self propel in the wheelchair. The PT completed an assessment in April, 2015 but had not assessed the resident for gait, gait pattern and/or ambulation/endurance or their ability to self propel in a wheelchair due to an identified wound. According to the progress notes the resident's alteration to their skin integrity had resolved in May, 2015. Interview with the PT confirmed they were unaware if the resident's alteration in skin integrity had resolved and stated they had not reassessed the resident or reviewed the plan of care when the resident's wound healed and their care needs changed. [s. 6. (10) (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 the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Specifically the licensee failed to comply with the following:
s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.
A. The licensee did not ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports.
i. The home's policy Zero Tolerance of Abuse and Neglect (N-10.11), directed staff to immediately report to the Ministry of Health and Long Term Car Director if there were reasonable grounds to suspect that an abuse of a resident has occurred.
ii. On an identified date in April, 2015, resident #600 voiced concerns that a particular staff member had been rough during care. This was immediately reported to the Registered Nurse.
iii. The nursing staff documented in resident #600's progress notes that the incident was reported in April, 2015, but did not immediately notify their supervisor or the Ministry of Health and Long term Care.
iv. The critical incident report was not submitted to the Director immediately; which was over 33 hours after the concerns were reported to registered staff.

The Chief Nursing Officer confirmed there was a delay in reporting this incident to the Ministry of Health and Long Term Care [s. 20. (1)]

2. B. The licensee did not ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports.
i. The home's policy Zero Tolerance of Abuse and Neglect (N-10.11), directed staff to immediately report to the Ministry of Health and Long Term Car Director if there were reasonable grounds to suspect that an abuse of a resident has occurred.
ii. In November, 2014, resident #602 had exhibited responsive behaviours towards a staff member. The identified staff member responded to the resident by calling the resident a name. This incident of verbal abuse was immediately reported to the Registered Nurse, however was not immediately reported to the Ministry of Health and Long Term care and was not reported until the following day. [s. 20. (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 their written policy that promotes zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. A review of the clinical record for resident #023 indicated they were admitted to the home in August, 2014 with a pressure ulcer to an identified area. The resident developed another pressure ulcer to another area in September, 2015. From August, 2014 to May, 2015 the resident continued to have varied levels of altered skin integrity to these two identified areas as confirmed in the progress notes. The home's Ulcer/Wound assessment tool and/or the Wound Care Observation progress note were not consistently completed weekly. There were two identified weeks in 2014 and four identified weeks in 2015 where there were no weekly reassessments of the resident's wounds.
Interview with the CNO confirmed the home used both the Ulcer/Wound assessment tool and the Wound Care Observation progress note to document the weekly reassessment of the resident's altered skin integrity and that the home had not reassessed the wounds weekly as required. [s. 50. (2) (b) (iv)]

B. A review of the clinical record for resident #400 indicated they were admitted to the home in September, 2014 with an identified diagnosis. The most recent plan of care indicated the resident was at risk for frequent skin tears related to their fragile skin and chronic progressive disease process. The clinical record indicated an admission Head to Toe Assessment was completed in September, 2014 that identified several areas of altered skin integrity.
From September, 2014 to December, 2014 the resident continued to have varied levels of altered skin integrity as confirmed in the progress notes. The home's Ulcer/Wound assessment tool and/or the Wound Care Observation progress note were not consistently completed weekly. There were three identified weeks where there were no weekly reassessments of the resident's wounds in 2014.
The resident's clinical record indicated they currently had a pressure ulcer to an identified area that was being treated with negative wound therapy.
Interview with the CNO confirmed the home used both the Ulcer/Wound assessment tool and the Wound Care Observation progress note to document the weekly reassessment of the resident's altered skin integrity. An interview with the RPN confirmed the home had not reassessed the wounds of resident #400 weekly as required during the months of September, 2014 and December, 2014. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, 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. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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 , (b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly.

A review of the 2014 Infection Prevention and Control Committee meeting minutes indicated the team had met only once, on December 11, 2014. The Home has met on February 5, 2015 and June 4, 2015. Interview with the Administrator confirmed the home's interdisciplinary team that co-ordinates and implements the program had not meet at least quarterly in 2014. [s. 229. (2) (b)]

2. The licensee has failed to ensure that a written record was kept relating to each evaluation under clause (d) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
A review of the Infection Prevention and Control Minutes did not indicate an annual evaluation of the Infection Control Program was completed. A review of the home's documents that contained program evaluations was completed with the CNO and an evaluation of the Infection Prevention and Control program was not completed. An interview with the CNO confirmed the Infection Prevention and Control program was not evaluated and updated at least annually in 2014 in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 229. (2) (e)]

3. The licensee has failed to ensure that the following immunization and screening measures were in place: 3. Residents must be offered immunizations against, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A review of the clinical record for resident #023, admitted August, 2014, and resident #400, admitted September, 2014 did not indicate the resident's had been offered immunizations against Tetanus and Diphtheria (Td). Interview with the RPN on the floor reviewed the admission form "Treatment Plan/Consent to Treatment" and stated the vaccinations for Td was not included on this form. Interview with the CNO confirmed the home had 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 the following immunization and screening measures were in place: 3. Residents must be offered immunizations against, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #6: 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 where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A. Resident #023 was interviewed and stated they received new clothing approximately three months ago and that some of this clothing was missing. The resident was able to provide a detailed account of the clothing items and confirmed they had sent the clothing to be labeled and reported the items to an unknown laundry staff when they went missing. The resident stated the items were still missing. The home's policy and procedure for lost and found items, document H-12.6, specified when an article of clothing was reported missing by a resident, family member or staff, that the 1B housekeeper would complete the lost and found form prior to looking for the items.
A review of the home's laundry and resident labeling book, confirmed the identified new items were received by the home for labeling within the last three months as specified by the resident. Interview with the 1B housekeeper, responsible for missing clothing, searched the required binder that contained the "Lost and Found Personals Form" and confirmed the form was not completed for the missing items. The 1B housekeeper confirmed they had not looked for the missing clothing and was not notified by a laundry staff member about the missing items. The 1B staff member confirmed that when missing item are reported to staff on the floor, the staff may perform an informal search for the items and not always complete the Lost and Found Personals Form. [s. 8. (1) (b)]

2. B. The home policy Skin and Wound Care Program N-9.14.1 indicated under the basic skin care requirements, procedure for PSW/HCA that staff were to document care provided and observations made each shift on the daily care record in Point of Care (POC).
Resident #004 was noted to be in a tilt chair. Staff reported on June 4, 2015 that they repositioned the resident every two hours because the resident no longer moved in the chair on their own, however, staff did not document this action in the resident's plan of care as per policy. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Personal Assistance Services Device (PASD) described in subsection (1) that was used to assist a resident with a routine activity of living included in the residents' plan of care.

Resident #004 was observed on June 3 and 4, 2015 in a wheel chair in the tilt position. Interview with staff confirmed that the resident was no longer able to move in the chair on their own and that they used the tilt to assist in repositioning the resident. Review of the resident's clinical record did not include the use of the tilt chair. The CNO confirmed on June 4, 2015 that the use of the tilt chair was a PASD and should be part of the resident's plan of care. [s. 33. (3)]

2. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if:
- The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #004 was observed in a tilt chair on June 3 and 4, 2015. The use of the tilt chair was confirmed to be a PASD and its' use was not consented to as confirmed with the CNO on June 4, 2015. [s. 33. (4) 4.]

WN #8: 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 was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.

Resident #002 had their weight recorded in November, 2014. A December, 2014 weight was found in the clinical record, however was crossed out by the RD. There was no other weight found or reweigh completed for December 2014 for the resident as confirmed with the RN on June 4, 2015. [s. 68. (2) (e) (i)]

WN #9: 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 were offered and available at each meal and snack.

During the initial lunch observation on May 25, 2015, the planned menu indicated that caramel pudding and minced fruit cup (as an option for those on a minced textured diet) were to be offered and available. These items were not offered and available: only regular and puree texture fruit cup were available and lemon mousse was served instead of caramel pudding. This was confirmed with the dietary aide on May 25, 2015. [s. 71. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the written report referred to in subsection 107 (4): subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
Resident #305 was transferred to hospital on an identified date in February, 2015 and returned the same day; however, was deemed palliative and remained unresponsive. The resident subsequently passed away.
The home failed to notify the Director when the resident was taken to hospital in February, 2015 and resulting significant change in the resident's health condition. [s. 107. (3) 4.]

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

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Issued on this 15th day of July, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156), IRENE SCHMIDT (510a), KELLY CHUCKRY (611), LESLEY EDWARDS (506), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2015_322156_0009
Log No. / Registre no:	H-002403-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 17, 2015
Licensee / Titulaire de permis :	ALBRIGHT GARDENS HOMES INC. 5050 Hillside Drive, Beamsville, ON, L0R-1B2
LTC Home / Foyer de SLD :	ALBRIGHT GARDENS HOMES, INCORPORATED 5050 Hillside Drive, Beamsville, ON, L0R-1B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOHN BUMA

To ALBRIGHT GARDENS HOMES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
The plan shall include a) strategies to prevent verbal abuse by staff towards resident #602 b) staff education on abuse and responsive behaviours including dates that the education will be completed and c) quality management activities (including the type of activities and frequency) that will be implemented to target the specific area of non-compliance.
The plan should be submitted via email by July 15, 2015 to Kelly Chuckry at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

In November, 2014 resident #602 exhibited responsive behaviours towards an identified Personal Support Worker (PSW). In response to this, the PSW called resident #602 a name. Resident #602 reported the incident to another identified PSW.
The Chief Nursing Officer (CNO) confirmed that the incident occurred and the staff member in question was disciplined as a result of the incident.
The PSW did not respond in a way that fully recognized resident #602's individuality and did not respect the residents dignity. (611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

Service Area Office /
Bureau régional de services : Hamilton Service Area Office