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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 13, 2018 | 2018_569508_0023 | 027606-18 | 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

ROSEANNE WESTERN (508)

## 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): October 26, 29, 30, 31, November 1, 2, 2018.**

**During the course of the inspection, the inspector toured the facility, observed the provision of care, reviewed relevant policies and procedures, resident clinical records and the home's internal investigative notes.**

**PLEASE NOTE: Complaint inspection #2018_569508_0022 was conducted concurrently during this CI inspection.**

**During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer (CNO), the Director of Nursing and Personal Care (DNPC), registered staff, Personal Support Workers (PSWs) and residents.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy regarding Zero Tolerance of Neglect and Abuse, N-10.11, last revised April, 2018, identified that all reporting of alleged, suspected, or witnessed incidents of abuse must be reported immediately by the person first having knowledge of the incident, and will be investigated immediately by the person's supervisor/manager/department head/administrator, in accordance with the investigation procedure under "Reporting and Notifications."

The policy also indicated under "Clinical/Registered Staff Response for Care of the Resident(s) that registered staff are to conduct a head-to-toe physical assessment on the alleged victim and document findings if physical abuse is alleged.

According to a Critical Incident (CI) , and the resident's clinical records, on an identified date in 2018, resident #001 reported to registered staff #004 that on an identified date, an incident of alleged abuse occurred towards this resident. The resident indicated that they had seen this individual earlier that evening in an identified area of the home.

The Registered Practical Nurse (RPN) #004 reported this to Registered Nurse (RN) #003 on duty and both staff met with the resident to review the resident's allegation of being abused. According to the resident's clinical record no further action was taken.

The following day, the Director of Nursing and Personal Care was notified by the Registered Nurse on duty that this allegation had been made by resident #001. The DNPC indicated during interview that the intent of the RN's phone call was to report staffing issues, not the allegation of abuse and the RN happened to mention this allegation during the phone call.

The DNPC directed the RN to call the Ministry of Health and Long Term Care Director (MOHLTC) to report this allegation and to conduct a head to toe assessment on the resident as directed in their policy. RN #003 passed along this information to RN #005 and did not complete a head-to-toe assessment of the resident.

RN #005 called and reported the allegation to the MOHLTC Director; however, did not conduct a head to toe assessment on the resident. The DNPC indicated during interview that a head-to-toe assessment had not been completed until a specified number of days later.

It was confirmed during record reviews and during interview with the DNPC that the licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

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**Issued on this 15th day of January, 2019**

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

**Original report signed by the inspector.**