Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 26, 2019	2019_704682_0015	005881-18, 029382-18, 029476-18, 031226-18, 031227-18	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

AILEEN GRABA (682), LISA BOS (683), STACEY GUTHRIE (750)

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 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 2019.

The following Compliance Order follow ups were conducted at the time of the Critical Incident System inspection,
031226-18 related to safe transfers and positioning
031227-18 related to plan of care and resident reassessments.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Nursing and Personal Care (DON), Associate Director of Nursing (ADON), Director of Dietary Services, Manager of Program and Support Services, Resident Assessment Instrument (RAI) Coordinator, nursing secretary/scheduler, nursing consultant, registered staff, personal support workers (PSW) and residents.

During the course of the inspection, the inspector(s) toured the home; reviewed resident health records; meeting minutes; staffing schedules and daily assignments, investigative notes, policies and procedures; Critical Incident System (CIS) submissions and observed residents and the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Pain
Personal Support Services

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 36.	CO #003	2018_720130_0010	683
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #007	2018_720130_0010	682

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	Légende 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer’s instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #008’s fall prevention safety device, was applied in accordance with the manufacturer’s instructions.

On an identified date, resident #008 was observed with a mobility aid and a fall prevention safety device. The safety device was observed to have been applied incorrectly. PSW #122 and RPN #123 observed the resident’s safety device and confirmed that it was applied incorrectly. A review of the written plan of care for resident #008, identified that they required a specific falls prevention safety device. On an identified date, the Director of Nursing and Personal Care (DON) provided what they identified as the manufacturer’s instructions for resident #008’s safety device. The document identified the application of the safety device. In an interview with the DON, they acknowledged that as per the observations and confirmation by PSW #122 and RPN #123, resident #008’s fall prevention safety device was not applied in accordance with the manufacturer’s instructions on an identified date. [s. 110. (1) 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 the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. staff apply the physical device in accordance with the manufacturer’s instructions, to be implemented voluntarily.

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. (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 written plan of care for resident #008 set out clear directions to staff and others who provided direct care to the resident.

A review of the transfer and re-positioning assessment, identified that resident #008 required assistance. A review of the written plan of care and Kardex in place for resident #008, identified resident #008 required assistance. A review of the logos above the resident’s bed identified that they required assistance. In an interview with the DON, they reviewed the transfer and repositioning assessment as well as the resident’s current written plan of care and acknowledged that resident #008’s written plan of care did not specify in which situation and the type of assistance resident #008 required. In an interview with the Associate Director of Nursing (ADON) and the home’s nursing consultant acknowledged that the resident’s written plan of care in place was unclear as to when and how the resident required assistance. The home did not ensure that the written plan of care for resident #008 set out clear directions to staff who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that resident #014 was reassessed and the plan of care reviewed and revised when their care set out in the falls prevention and management plan was not effective.

A critical incident (CI) was submitted to the Director, 2018, related to a fall of resident #014, which resulted in an injury. A clinical record review indicated that resident#014 was assessed as a fall risk on an identified date. Further review indicated that resident's #014 plan of care included a focus for falls risk and fall prevention interventions. Resident's #014 progress notes identified the resident had sustained falls on identified dates. During an interview, the ADON stated that there was no evidence of additional fall prevention strategies initiated or revisions to the plan of care when the current plan of care was ineffective in preventing falls for resident #014. The ADON confirmed that resident #014's plan of care was not reviewed and revised when the care related to fall prevention and management set out in the plan had been ineffective.

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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1), the licensee was required to have a falls prevention and management program that provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, registered staff did not comply with the licensee's policy N-9.5.6, titled Falls Prevention and Management policy, revised on April, 1, 2017 that directed registered staff to do the following: "At weekly fall rounds, the RN or designate will provide an overview of the resident's fall, actions which have been taken to address the falls risk (changes to care plan, urgent referral to physiotherapy, transfer to hospital). Following the discussion and recommendations, the RN will document the discussion, update the care plan as required, and complete any referrals resulting from the meeting. "

A CI was submitted to the Director, related to a fall of resident #014, which resulted in an injury. A clinical record review indicated that resident #014 was assessed as a fall risk. Further review indicated that resident's #014 plan of care included a fall risk focus and interventions. Resident's #014 progress notes indicated that resident had sustained a fall on identified dates. There was no documentation in resident's #014 plan of care that there was discussions or recommendations made regarding resident's #014 falls during weekly fall rounds.

During an interview, staff #127, stated that fall "huddles" were arranged to meet the licensee's policy requirement related to the "weekly fall rounds". Staff #127 stated that these huddles were documented. Staff #127 confirmed that between identified dates, there was no evidence that huddles or meetings occurred. Staff #127 confirmed that discussions regarding resident #014 falls at weekly fall rounds was not done and registered staff did not comply with the home's fall prevention and management policy.

Issued on this 17th day of July, 2019

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

Original report signed by the inspector.