Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 17, 2019	2019_543561_0025	017521-19, 018689-19, 019634-19, 020183-19	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

DARIA TRZOS (561), LISA BOS (683)

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): November 22, 25, 26, 27, 28, 29, 2019 and December 3, 4, 5, 6, 9, 2019.

The following Critical Incident System (CIS) intakes were completed during this inspection:
C501-000042-19, log #017521-19 - related to alleged neglect of a resident,
C501-000051-19, log #020183-19 - related to alleged abuse of a resident,
C501-000049-19, log #019634-19 - related to unlawful conduct that resulted in risk of harm to resident,
C501-000045-19, log #018689-19 - related to a fall causing an injury.

A Complaint Inspection number 2019_543561_0026 was also completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Nursing and Personal Care (DONPC), Associate Director of Nursing (ADON), Manager of Program and Support Services, Director of Dietary Services, Physiotherapist (PT), Occupational Therapist (OT), Minimum Data Set (MDS) Coordinator/Falls Lead, Nursing Secretary, Registered staff including Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, Dietary staff, Maintenance staff, Recreation staff, Restorative staff, residents, CEO at the Devine Home Care agency, Administrative Assistant at National Association of Career Colleges (NACC), Auditor at NACC, Administrative Assistant to the Director at Private Career Colleges Branch of Ministry of Training, Colleges and Universities, and Records and Registration Coordinator from the Personal Support Worker Registry of Ontario.

During the course of the inspection, the inspector(s): observed provision of care, observed meal services, reviewed clinical records, relevant polices and procedures, staff schedules, training records, investigation notes, and any other documents relevant to the investigation.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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

- **5 WN(s)**
- **5 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) The plan of care for resident #001 identified that the resident sustained a fall on an identified date in 2019, which resulted in an injury. Prior to the fall, the plan of care for the resident indicated that the resident was independent with activities of daily living (ADLs). Progress note after the identified fall, stated that the resident's status for identified ADLs was changed. The written plan of care in place after the identified fall was reviewed and did not reflect the change in the level of assistance for the identified ADLs.

PSW #129 who provided direct care to the resident was interviewed and indicated that after the fall in 2019, the resident required total assistance ADLs.

The review of the investigation notes into the fall indicated that the written plan of care was not revised with the change in level of assistance for identified ADLs. In an interview with the ADON they stated that the registered staff failed to update the care plan with the change in the level of assistance for this resident after the fall in 2019.

The home’s policy titled “Falls Prevention Program”, Document N-9.5.1, revised July 19, 2019, indicated that the plan of care needed to be adjusted upon change of condition or when a resident needs change.

B) On an identified date in 2019, Inspector #561 observed resident #001’s room and reviewed the Kardex which was posted on the wall by the resident’s bed. The Kardex stated that the resident was to be transferred with an identified level of assistance, it did not include interventions related to falls, and under the 'toileting' section, it listed a specified intervention.

Interviewed PSW #129 who provided direct care to the resident and they stated that resident #001's level of assistance for transfers had changed recently and the Kardex that was posted on the wall was outdated. The resident was assessed by the PT recently and the level of assistance had changed as a result. Furthermore, the PSW indicated that the resident had recent changes related to toileting and the Kardex did not include current interventions related to the prevention of falls.

Inspector #561 reviewed the written plan of care and it was not revised with the changes related to the transfer status. The progress note on an identified date in 2019, stated that resident was reassessed for transfers and the status was changed.

Interviewed the ADON and they confirmed that the written plan of care was not revised when there was a change in the transfer status. They also confirmed that the Kardex which was being used by PSWs and posted on the wall by the bed, was not revised to include the changes for identified ADLs.

The home's policy titled "Falls Prevention Program", Document N-9.5.1, revised July 19, 2019, indicated that the plan of care needed to be adjusted upon change of condition or when a resident needs change.

C) Review of the progress note on an identified date in 2019, indicated that resident #001's family member requested the resident to be assessed for a mobility device since they were unsteady on their gait. Physiotherapist (PT) assessed the use of the mobility device and sent a referral to Occupational Therapist (OT) to come in and further assess the resident and measure them for an appropriate device. There was no documentation indicating that the OT had assessed the resident. Interview with OT stated that they did not assess the resident after the referral was made on an identified date in 2019. OT stated that the referral was missed.

The interviews with staff including the registered staff #118, #105, #104, PSW #114 and the PT indicated that the resident was using a mobility device. The written plan of care did not specify that the resident was using the identified device and there was no assessment for the use of it.

The ADON was interviewed and explained the process in place for assessing and ordering mobility devices, which included the assessment by the OT. The OT would document the assessment in the plan of care and registered staff would then update the care plan to include the use of the mobility device. The ADON reviewed the care plan and stated that the care plan did not indicate that the resident was using a mobility device.

The licensee 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 the resident's care needs changed related to falls and identified assistance levels for ADLs. [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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee failed to ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) had successfully completed a personal support worker program that met the requirements in subsection (2); and
(b) had provided the licensee with proof of graduation issued by the education provider.

The home submitted a CIS report to the Ministry of Long Term Care (MOLTC) on an identified date in 2019, related to agency hired personal support workers (PSWs) providing fraudulent documentation of certifications to the home.

Inspector #561 interviewed the DONPC and they stated that the home entered into a contract with a third party in 2019. The home did not obtain records of the PSW

certifications at the time of hiring. The DONPC stated that they had concerns with the agency PSWs, and requested to see the certifications of the PSWs from the identified agency. The agency informed the home that all PSW staff were qualified to work as PSWs and provided only few certificates to the home. Two of the certificates were altered as they had the same graduate number. One was issued to staff #141 and the other to staff #142. The home ended the contract with this agency once they identified that the certificates were fraudulent.

Inspector #561 obtained a list of all PSWs that were hired through the identified agency. The list contained 29 names. The home was able to obtain only nine copies of the PSW certificates from the agency. Out of the nine certificates, three of them belonging to staff #141, #142 and #143 had definitely been altered. The names and dates had a different font than other font on the certificate, were not aligned with the underline and had the same graduate number on the certificates.

Inspector #561 interviewed the Auditor that was in the process of investigating this case at the NACC. The Auditor indicated that there was a number of forged certificates for PSWs that worked at home, that were supplied by the identified agency. The Auditor forwarded a document to Inspector #561 specifying that certificates belonging to staff #141, #142 and #143 were forged and therefore, were not qualified to work as PSWs. The Auditor from NACC was in the process of investigating and looking into the certificates of other staff employed by this agency, with the potential for staff working as PSWs who were not qualified.

The licensee failed to ensure that every person hired by the licensee as a Personal Support Worker had successfully completed a personal support worker program that met the requirements in subsection (2); and had provided the licensee with proof of graduation issued by the education provider. [s. 47. (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 on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, (a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and (b) has provided the licensee with proof of graduation issued by the education provider, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below:
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

A) A CIS report was submitted to the Director on an identified date in 2019, under the category of staff to resident neglect. As per the CI, internal investigation notes, and staff interviews, PSW #122 who worked in the home through an employee agency, was responsible for the care of resident #002 on an identified date and it was believed that they left the resident on the toilet for several hours.

During this inspection, staff #123 provided Inspector #683 a list of the dates that PSW #122 worked in the home. The document indicated that the identified PSW worked in the home for several months in 2019.

In an interview with the DONPC, they identified that the home used a third party for PSWs when they were unable to fill shifts with their staffing compliment. The DONPC acknowledged that the manager of the identified agency was asked if all mandatory training was completed at the agency and they indicated that it was, but did not provide them any records of the training. The DONPC acknowledged that they were not aware that the home was required to train agency staff on the home's policy to promote zero tolerance of abuse and neglect of residents and confirmed that PSW #122 was not trained on the home's policy to promote zero tolerance of abuse and neglect of residents, before providing their services.

B) The DONPC acknowledged that they were not aware that the home was required to train agency staff on the home's policy to promote zero tolerance of abuse and neglect of residents and confirmed that all PSWs, including PSW #141, #142 and #143 employed through a third party, agency, were not trained on the home's policy to promote zero tolerance of abuse and neglect of residents, before providing their services.(561)

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training related to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (2) 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 no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A CIS report was submitted to MOLTC related to a medication incident that caused harm to resident #003.
The home's investigation notes indicated that on an identified date in 2019, resident #003 was forced by RPN #107 to take medications, which they believed were not theirs. In an interview with the home, the resident stated that they took approximately 17 medications in the morning each day and the RPN had brought only eight to them that day. The incident report identified that a number of medications were omitted, and the resident did not take all prescribed medications scheduled to be administered on the identified date. There were eight medication that remained in the pouches inside the investigation file.

The clinical records were reviewed and indicated that resident #003 was prescribed 17 tablets of different medications to be administered on the day of the incident. Three of the medications that were prescribed to be administered at 0800 hours were high risk medications.

Electronic Medication Administration Record (EMAR) was reviewed and indicated that RPN #107 signed that they administered all 17 medications, including the high risk medications. When the home interviewed the RPN, they denied making an error and stated that they administered all medications as prescribed.

Resident #003 was interviewed by the Inspector and was able to recall that a registered staff member forced them to take medications that were not theirs.
Inspector #561 was unable to interview the register staff in question.

The interview with the ADON identified that RPN #107 had made the medication error and failed to administer all medication to resident #003 as prescribed. They stated it was evident they did not administer all medications since there were still seven remaining, including the high risk medications, in the pouches from the date of the incident.

The licensee failed to ensure that resident #003 received medications as prescribed. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1); O. Reg. 451/18, s. 4.

Findings/Faits saillants :

1. The licensee failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: 1. The staff member’s qualifications, previous employment and other relevant experience. 3. Where applicable, the
results of the staff member’s police record check under subsection 75 (2) of the Act.

A) A CIS report was submitted to the Director on an identified date in 2019, under the category of staff to resident neglect. As per the CI, internal investigation notes, and staff interviews, PSW #122 who worked in the home through an employee agency, was

responsible for the care of resident #002 on an identified date and it was believed that they left the resident on the toilet for several hours.

Inspector #683 requested the employee file for PSW #122 from the DONPC. They indicated that the identified staff member was not an employee of the home, they were from an identified employment agency in which the home no longer used. Upon request for PSW #122's certificate of registration and criminal reference check, the DONPC indicated that the home required vulnerable sector screening of agency staff, but noted that was the responsibility of the agency to obtain. They indicated that until recently, the home did not require the agency to send copies of the criminal reference check and PSW certification, and acknowledged that the home did not have copies of either document for PSW #122.

B) The home submitted a CIS report to the MOLTC on an identified date in 2019, related to agency hired personal support workers (PSWs) providing fraudulent documentation of certifications to the home.
Inspector #561 interviewed the DONPC and they stated that the home entered into a contract with a third party, an agency on an identified date in 2019. The home did not obtain records of the PSW certifications and their criminal record checks. The records were not kept for all staff from the identified agency, specifically PSW #141, #142 and #143 that were looked at. The DONPC stated that they entrusted the agency would have checked all the PSWs certificates and police records checks. The home did not keep files of the PSWs qualifications, experience and criminal reference checks hired through the third party.
The Chief Executive Officer confirmed the same.

The licensee did not keep records for each staff member employed through an agency that included their qualifications, previous employment, experience and their police record checks. [s. 234. (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 a record is kept for each staff member of the home that includes at least the following with respect to the staff member: 1. The staff member's qualifications, previous employment and other relevant experience. 3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act, to be implemented voluntarily.

Issued on this 10th day of January, 2020

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

Original report signed by the inspector.