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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Feb 21, 2020	2020_661683_0004	001183-20	Complaint

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

LISA BOS (683)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 11, 12, 13, 14 and 19, 2020.

This inspection was completed concurrently with critical incident system inspection #2020_661683_0005.

The following intake was completed during this complaint inspection:
Log #001183-20 was related to the prevention of abuse and neglect, responsive behaviours, skin and wound, and medication administration

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Associate Director of Nursing (ADON), registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, investigation notes, policies and procedures, training records and observed residents during the provision of care

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 when resident #001 exhibited altered skin integrity, that they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and that they were assessed by a registered dietitian, who was a member of the staff of the home.

A complaint was submitted to the Director in relation to an incident which resulted in injury to resident #001.

A review of the home's internal investigation notes and the clinical record for resident #001 indicated that on an identified date, staff were providing care to the resident and they noted an area of altered skin integrity.

A review of the clinical record did not identify an assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment for the resident's area of altered skin integrity. A review of the clinical record also did not identify a referral to or assessment by the Registered Dietitian (RD) related to the area of altered skin integrity.

In an interview with the Associate Director of Nursing (ADON), they acknowledged that a skin assessment should have been completed for resident #001's area of altered skin integrity using a clinically appropriate assessment instrument and there was no documentation of this being completed. They also acknowledged that the resident was not assessed by the RD in relation to their area of altered skin integrity.

The home did not ensure that resident #001 received a skin assessment using a clinically appropriate assessment instrument and that a referral was made to the RD for an area of altered skin integrity. [s. 50. (2) (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 a resident exhibiting altered skin integrity 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 and 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, to be implemented voluntarily.

WN #2: 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 has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any protocol, the protocol was complied with.

In accordance with O. Reg. 79/10 s. 114, the licensee was required to have an interdisciplinary medication management system that included written policies and protocols for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs in the home.

Specifically, staff did not comply with the licensee's protocol titled "Standardized Minimum Capillary Blood Glucose (CBG) Testing," dated November 2010, which was part of the licensee's medication management system. The protocol outlined that a hypoglycemic risk assessment was to be completed for any CBG below 4.0, four times a day for five days and the results were to be presented to the physician upon completion.

A complaint was submitted to the Director in relation to the monitoring of resident #001 when they had low blood sugars.

A review of the clinical record for resident #001 indicated that they had a diagnosis of diabetes mellitus for which they received medication. Their blood sugar summary report, progress notes and eMAR (electronic Medication Administration Record) were reviewed and three occasions were identified where their blood sugar measured less than 4.0.

There was no documentation in the blood sugar summary report, the progress notes or the eMAR that the resident's blood sugar was measured four times a day for five days after their blood sugar was measured as less than 4.0 mmol/l on the three identified dates.

In an interview with the ADON, they acknowledged that the resident's CBG was not measured four times a day for five days after their blood sugar was below 4.0 on the three identified dates, as per the home's "Standardized Minimum CBG Testing" protocol. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were developed and implemented to respond to resident #001's behaviours.

A complaint was submitted to the Director in relation to an incident which resulted in injury to resident #001.

A review of the progress notes and interviews with PSWs #108, #111, #112 and Registered Practical Nurse (RPN) #102 indicated that resident #001 had known behaviours.

A review of the written plan of care and Kardex for resident #001 did not identify that they had behaviours and there were no strategies identified to respond to the resident's behaviours.

In an interview with RPN #102, they indicated that if a resident had behaviours, it would be identified in their written plan of care and Kardex. They reviewed the written plan of care and Kardex for resident #001 and acknowledged that they did not identify anything related to their behaviours, and that they should have.

In an interview with the ADON, they acknowledged that the resident's written plan of care and Kardex did not identify anything related to their behaviours, and they should have.

The home did not ensure that strategies were developed and implemented to respond to resident #001's behaviours. [s. 53. (4) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure for that every written complaint made to the licensee concerning the care of a resident, a response was provided within 10 business days of the receipt of the complaint.

A complaint was submitted to the Director in relation to the care of resident #001 and an incident which resulted in injury to resident #001.

On an identified date, a letter was submitted to the home which identified concerns about the incident and requested the home to investigate.

The home provided the complainant with a response letter on an identified date, which was greater than 10 business days from the receipt of the complaint.

In an interview with the Chief Executive Officer (CEO), they acknowledged that the home did not provide a response within 10 business days of the receipt of the complaint related to the care of resident #001.

The home did not ensure that they provided a response within 10 business days upon receipt of the written complaint regarding the care of resident #001. [s. 101. (1) 1.]

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.