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
Nov 12, 2020	2020_704682_0012	015129-20, 016122-20	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)

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 8, 9, 13, 14, 15, 16, 19, 20, 21, 22, 23, 2020.

The following Critical Incident System inspection(s) were conducted:
016122-20 related to fall prevention
015129-20 related to fall prevention

The following complaint inspection(s) were conducted concurrently with this Critical Incident System inspection:
018447-20 related to admission/ discharge
018626-20 related to staffing
018644-20 related to staffing
018674-20 related to staffing
019029-20 related to prevention of abuse and neglect
019057-20 related to prevention of abuse and neglect

The following compliance order follow up inspection was conducted concurrently with this Critical Incident System inspection:
000607-20 related to personal support services

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Nursing Officer (CNO), Associate Director of Nursing (ADON), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nursing Secretary, Executive Assistant and residents.

During the course of this inspection, the inspector observed the provision of the care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, program evaluations, staff training records, policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care related to falls prevention for a resident that sets out clear directions to staff and others who provide direct care.

A resident was assessed as a fall risk. The resident's care plan identified various fall prevention interventions. The PSW stated in an interview that the resident did not require a certain intervention that was in the care plan. Progress notes indicated that a RPN removed the fall intervention. The Associate Director of Nursing (ADON) confirmed in an interview, the plan of care did not provide clear direction to staff related to the resident's fall prevention interventions.

Sources: Care plan, progress notes, interviews with PSW and the ADON. [s. 6. (1) (c)]

Issued on this 16th day of November, 2020

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

Original report signed by the inspector.