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_0011	018447-20, 018626-20, 018644-20, 018674-20, 019029-20, 019057-20	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

AILEEN GRABA (682), 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): October 8, 9, 13, 14, 15, 16, 19, 20, 21, 22, 23, 2020.

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

The following compliance order follow up inspection was conducted concurrently with this Complaint 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(s) 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:
Admission and Discharge
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

2 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. 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 failed to ensure that, for a resident, demonstrating responsive behaviours, strategies were implemented to respond to these behaviours, where possible.

A resident's care plan indicated that they exhibited responsive behaviours towards co-residents. The resident's plan of care also included strategies to decrease responsive behaviours. Despite the interventions, progress notes and investigative notes indicated that the resident continued to exhibit responsive behaviours on identified dates. In an interview, two RPN's both stated the resident required strategies to prevent responsive behaviours. The Associate Director of Nursing (ADON) confirmed that a specific strategy was not implemented on identified dates to respond to the resident. Because strategies were not implemented to respond to the resident when they had responsive behaviours, co-residents were placed at a risk for harm.

Sources: The LTCH's investigative notes, care plan, progress notes and interview with RPN and ADON. [s. 53. (4) (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, for residents demonstrating responsive behaviours, strategies are implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was protected from abuse by resident #002.

Resident's #002 care plan identified a history of responsive behaviour towards co-residents. Resident #002 had several interventions identified to respond to responsive behaviours. Progress notes and investigative notes indicated that resident #002 was discovered by staff and had abused resident #001. In an interview, an RPN stated that resident #002 required strategies to respond to their responsive behaviour and resident #001 was not protected from resident #002.

Sources: The LTCH's investigative notes, care plan, progress notes and interview with RPN [s. 19. (1)]

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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.