

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

Public Copy/Copie du rapport public

Report Date(s) /	Inspection No /	Log # /	Type of Inspection /
Date(s) du Rapport	No de l'inspection	No de registre	Genre d'inspection
May 19, 2021	2021_704682_0006	000214-21, 000472- 21, 002511-21, 002986-21	Complaint

Licensee/Titulaire de permis

Albright Gardens Homes, Incorporated 5050 Hillside Drive Beamsville ON LOR 1B2

Long-Term Care Home/Foyer de soins de longue durée

Albright Gardens Homes, Incorporated 5050 Hillside Drive Beamsville ON LOR 1B2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection



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

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

This inspection was conducted on the following date(s): April 20, 21, 22, 23, 26, 27, 29, 30, 2021, May 4 and 5, 2021.

This inspection was completed concurrently with Critical Incident inspection 2021_704682_0007.

The following intakes were completed during this complaint inspection: 000214-21 related to resident bill of rights 000472-21 related to safe lift and transfers 002511-21 related to plan of care, fall prevention 002986-21 related to fall prevention

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer (CNO), the Associate Director of Nursing (ADON), Scheduling Coordinator, Housekeeping, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, Ontario's Coroner office and Niagara Region Public Health staff.

During the course of the inspection, the inspector(s) toured the home; reviewed investigative notes, critical incident submissions, staffing schedules, resident health records, newsletters, policies and procedures, Critical Incident System (CIS) submissions; outbreak management documentation, observed infection prevention and control (IPAC) practices, residents and provision of care.

The following Inspection Protocols were used during this inspection: Falls Prevention Personal Support Services Prevention of Abuse, Neglect and Retaliation Safe and Secure Home

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

1 WN(s) 1 VPC(s) 0 CO(s) 0 DR(s) 0 WAO(s)



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

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			INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2020_661683_0023	682



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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES				
Legend	Légende			
 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order 	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).	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.			
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

3. Every resident has the right not to be neglected by the licensee or staff. 2007,



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

c. 8, s. 3 (1).

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1). 7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1). 12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).



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

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1). 23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).



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

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents rights to receive visitors of their choice was fully respected and promoted.

A complaint was received regarding the home suspending all essential visitors. A review of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, and the Ministry of Long Term Care (MLTC) COVID-19 Visiting Policy stated a maximum of one essential caregiver/visitor per resident may visit while the home is in an outbreak, subject to direction from the local public health unit.

The licensee's newsletter, informed all residents, family members and employee's that "all essential caregiver visits were suspended due to outbreak." A review of outbreak correspondence/ documentation between the licensee and local public health unit did not include the direction by the local public health unit to suspend all essential caregiver visits.

The Associate Director of Nursing (ADON) indicated the local public health unit had provided the direction of suspending all essential caregiver visits during the outbreak. The ADON confirmed that all essential caregiver visits were suspended for an identified time period. Consultation with the local public health nurse identified there was no indication that suspending all essential caregiver visits was a direction that was provided by the public health unit. The licensee's denial of essential caregiver visits resulted in residents being prevented from having unrestricted access and supportive care related to communication, companionship, religious support, safety monitoring and personal care from their caregiver.

Sources: Complaint, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, The Ministry of Long Term Care (MLTC) COVID-19 Visiting Policy, Albright News Flash (newsletter), interview with the ADON, and others. [s. 3. (1)]



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

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 the following rights of residents are fully respected and promoted: every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, to be implemented voluntarily.

Issued on this 21st day of May, 2021

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

Original report signed by the inspector.