Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
November 3, 2010	2010_146_8501_02Nov082829	Complaint H-0217

Licensee/Titulaire
Albright Gardens Home Incorporated, 5050 Hillside Drive, Beamsville, ON.,L0R 1B2

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

Albright Gardens Home Incorporated, 5050 Hillside Drive, Beamsville, ON.,L0R 1B2

Name of Inspector(s)/Nom de l'inspecteur(s)
Barbara Naykalyk-Hunt #146

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Complaint inspection related to resident care.

During the course of the inspection, the inspector spoke with: the Administrator, the Director of Nursing and Personal Care (DOC), a receptionist and an administrative assistant.

During the course of the inspection, the inspector: reviewed the health file of the resident, observed the resident in the lounge and observed the resident's room.

The following Inspection Protocols were used during this inspection: Minimizing of Restraining and Personal Support Services.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O.2007, c.8, s.31(2)
31(2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Findings:
1.According to the progress notes of an identified resident, the wheelchair seatbelt was used on at least 3 occasions in July 2010 after the physician's order was written in the previous month to discontinue the seatbelt:

2. According to the progress notes of an identified resident, the substitute decision-maker (SDM) had clearly expressed to nurses on several occasions that consent to the use of a restraint on the resident was not provided.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6(10)

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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

Findings:

1. According to the health file, an infection note was made on Day 1 by the nurse describing signs of an infection. The note states "will have the doctor look at it if needed" on Day 3. No further documentation is in the health file about the signs of the infection until Day 20 when a nurse charted that the SDM had come to her about the infection.
There was no re-assessment of the resident's infection (changing care need) after the initial assessment of

Day 1 until Day 20, resulting in no change/review in the plan of care until Day 21 when the SDM took action.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Barbara Daydelyk-Hess Dec 6 / 2010
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).