Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 28, 2012	2012_214146_0005	H-002261-12	Critical Incident System

Licensee/Titulaire de permis

ALBRIGHT GARDENS HOMES INC.
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

BARBARA NAYKALYK-HUNT (146)

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): December 21, 2012

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), registered staff, Personal Support Workers (PSW) and a resident.

During the course of the inspection, the inspector(s) reviewed a specific resident's health record; policy and procedures related to lifts and transfers and shift routines; manufacturer's instructions for Arjo lift and observed a specific resident.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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).

Findings/Faits saillants :

1. The Licensee did not ensure that the resident's following right was respected and promoted: 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. In December 2012 resident 001 was assisted onto the bathroom and left there for a defined period of time. This information was confirmed by the DOC, staff and the health record. [s. 3. (1) 1.]

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 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, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants : The Licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. The plan of care for resident 001 identified specific routines that were to be followed. Care as outlined in the plan of care was not provided to the resident in December 2012 when the resident was left unattended in the bathroom for a defined period of time. This information was confirmed by the Director of Care, the notes of staff interviews and the health record. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 residents are not neglected by the licensee or staff. In December 2012 resident 001 was assisted into the bathroom and left there for a defined period of time. This information was confirmed by the DOC, staff and the health record. [s. 19. (1)]

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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: 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 did not ensure that the home's plan, policy, protocol, procedure, strategy or system was complied with. The home has written shift routines/procedures specific to the unit where resident 001 resides which state that the PSW assigned to a specified routine is to provide specified care to resident 001. The procedure for the PSW assigned to a second specified routine also states to provide specified care to resident 001.

Care routines were not followed by the staff as confirmed by the Director of Care, the staff interview notes and resident 001's health record in December 2012 when the resident was left in the bathroom for a defined period of time.
[s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The Licensee did not ensure that the resident had his/her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. In December 2012, resident 001 was assisted to the bathroom and left for a defined period of time. The resident complained of discomfort when removed from the bathroom. According to staff interview notes, the resident's normal desired bedtime routine was not complied with.
[s. 41.]

Issued on this 31st day of December, 2012

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

BARB NAYKALYK-HUNT