Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Aug 12, 2013	2013_202165_0012	H-000048-13	Complaint

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

TAMMY SZYMANOWSKI (165)

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): August 8, 9, 2013

During the course of the inspection, the inspector(s) spoke with residents, Director of Care (DOC), Food Service Manager (FSM), Administrator, Registered staff, and staff

During the course of the inspection, the inspector(s) observed meal service, reviewed menus and reviewed policies and procedures

The following Inspection Protocols were used during this inspection:
Dining Observation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 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. Where the Act or this Regulation required the licensee of the long term care home to have , institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.
A) The home's policy for "The Medication Pass policy 12-5" directed staff to ensure that all medication have been taken by the resident during a medication pass. On August 9, 2013, registered staff was observed during the breakfast meal leaving medication at the dining table for resident #1 and #2, without witnessing the resident consuming the medication. Resident #3 was provided their medication however; the registered staff did not stay and witness the medication being taken. Resident #4 had medication left on the dining table and dropped a pill during their attempt to consume their medication unsupervised. A table mate indicated that the resident had dropped a pill and the registered staff then returned to the table. [s. 8. (1) (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 where the Act or this Regulation requires the licensee of the 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, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.
A) The planned menu for the lunch meal August 8, 2013, indicated mandarin oranges however; only one regular portion was available to offer residents. It was noted that there was no minced or pureed mandarin oranges available.
B) Choice of dessert was not offered to residents who required puree texture. Puree apricots and applesauce were available and labeled for residents however; the alternate ice cream dessert was not offered.
C) The planned menu indicated yogurt for the breakfast meal August 9, 2013, however; yogurt was not offered to residents. [s. 71. (4)]

Issued on this 20th day of August, 2013

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