Ontario

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 9, 2015	2015_205129_0016	H-002779-15/H-002704-15	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

PHYLLIS HILTZ-BONTJE (129)

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): July 27, 28, 29, 2015

Two Critical Incident Inspections completed during this inspection Log # H-002779-15 and Log #H-002704-15.

During the course of the inspection, the inspector(s) spoke with residents, registered nursing staff, staff responsible for the documentation of staff education and the Administrator. The inspector also reviewed clinical record information, investigative notes compiled by the home, education and training documentation as well as the home's policy "Zero Tolerance of Abuse and Neglect" and the "Position Description - Registered Nurse (RN)".

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	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 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 :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [6(7)]
Resident #001's plan of care directed that the resident's preference was to be bathed and that a bath would be provided to the resident. Staff did not follow this direction when on May 29, 2015 Personal Support Worker(PSW) staff assisted the resident to the bath/shower room and began to shower the resident. When the resident asked why they were not getting a bath, one of the PSW staff told the resident that they would not be getting a bath until they were reassessed. The resident was unaware of this or the reason a reassessment was required. The clinical record did not indicate that the resident could not be bathed. [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 and ensuring 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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002's plan of care was based on, at a minimum, an interdisciplinary assessment of identified responsive behaviours, in relation to the following: [26(3) 5]
Clinical documentation included in resident #002's plan of care confirmed that the resident demonstrated two responsive behaviours. Staff documented that the resident demonstrated one of the responsive behaviours on July 18, 19, 20, twice on the 22nd, twice on the 23rd, twice on the 24th, twice on the 26th, 27 and 28, 2015. Documentation also confirmed that the resident demonstrated the second responsive behaviour on July 17, twice on the 18th, 19, 20, 21, twice on the 22nd, 23, 24, and 25, twice on the 26th, twice on the 27th and the 28, 2015. Staff and the clinical record confirmed that the resident's plan of care related to the demonstration of the two identified responsive behaviours was not based on an assessment of these behaviours and the plan of care did not provided direction for staff in the management of these behaviours. [s. 26. (3) 5.]

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 and ensuring that the residents plan of care is based on, at a minimum, an interdisciplinary assessment of identified responsive behaviours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental; written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours; resident monitoring and internal reporting protocols and protocols for the referral of residents to specialized resources where required were developed to meet the needs of residents with responsive behaviours. [53(1) 1, 2, 3, 4]
At the time of this inspection, registered staff and policies and procedures available to staff confirmed that there were no policies, procedures or protocols that included the requirements in accordance with O.Reg. 79/10, s. 53(1). The Administrator and registered staff confirmed that the Chief Nursing Officer was in the process of developing the required written approaches to care for resident's who demonstrated responsive behaviours. [s. 53. (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 and ensuring that the Licensee develops the required approaches to care identified in regulation 53(1), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for, at least 35 hours per week. [213(1) 5]
The Administrator and registered nursing staff confirmed that at the time of this inspection the Chief Nursing Officer was not in the home and was on a two week vacation. The Administrator and registered nursing staff also confirmed that there was not a person functioning in the capacity of the Chief Nursing Officer and that it was the expectation the registered nurses who were scheduled to perform their regular duties in accordance with their position description were also expected to perform the role of Chief Nursing Office over this period of vacation. [s. 213. (1) 5.]

Issued on this 9th day of September, 2015

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

Original report signed by the inspector.