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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2018	2018_569508_0022	016516-18	Complaint

Licensee/Titulaire de permis

Albright Gardens Homes, Incorporated
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

ROSEANNE WESTERN (508)

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): October 26, 29, 30, 31, November 1, 2, 2018.

During the course of the inspection, the inspector toured the facility, observed the provision of care, reviewed relevant policies and procedures, resident clinical records, home's internal investigative notes, 2018 complaint log and reviewed video recordings.

PLEASE NOTE: This complaint inspection was conducted concurrently during a Critical Incident inspection, report #2018_569508_0023.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer (CNO), the Director of Nursing and Personal Care (DNPC), registered staff, Personal Support Workers (PSWs), Nursing Unit Clerk, residents and family members.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 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	Légende 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 the resident as specified in the plan.

Resident #100 was identified as a risk for falls. A review of the resident’s current plan of care indicated that the resident had fall interventions in place while the resident was in bed.

During this inspection, it was observed on an identified date, that resident #100 was in bed sleeping. The Long Term Care Home (LTCH) Inspector observed the resident’s fall intervention was not in place while the resident was in bed.

Registered staff #002 was immediately informed by the LTCH inspector and confirmed that this intervention should have been place.

It was confirmed through observation and during interview with registered staff #002, that the care set out in the plan of care was not provided to the resident as specified in the plan. [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 #2: 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 were protected from abuse by anyone and

that residents were not neglected by the licensee or staff.

Resident #100 was identified as a risk for falls. The resident used an assistive aid for mobility; however, the resident still required the assistance of one to two staff for transfers and mobility.

A review of the resident's clinical record and a Critical Incident (CI) report, indicated that on an identified date in 2018, the resident sustained an injury from an unwitnessed. The documentation indicated that the resident was found on the floor, lying on their back with no shoes or socks on, near their mobility device. An alarm was going off which alerted staff to the room.

During a review of information provided regarding the incident, it was observed that there was additional information that had not been documented in the resident's clinical record or in the CI report.

It was observed during review of this information that PSW, staff #001 came into the resident's room at an identified time in the evening. There was no alarm ringing at this time.

The resident was attempting to get out of their bed and indicated that they had to go to the bathroom.

Staff #001 assisted the resident out of bed, putting their assistive device in front of them. The staff assisted the resident; however the resident requested assistance from another staff member. An alarm in the resident's room could be heard ringing at this time.

Staff #001 left the resident standing alone with their assistive device, shut off the alarm that had been activated and left the room.

The resident was left standing on their own with the assistive device, then was observed falling over and screamed out. There was no evidence of staff in the room at this time. Although staff #001 was no longer employed at the home during the time of this inspection, the LTCH Inspector conducted a telephone interview with this PSW.

During this interview, the staff confirmed that they left the resident standing on their own with their assistive device to go get another PSW who was on dinner break at the time of the incident. The staff indicated that the resident demonstrated responisive behaviours with them and therefore left the resident to get help.

Within minutes, the resident had fallen.The resident was then transferred to hospital by ambulance where it was confirmed the resident sustained a serious injury.

For the purposes of the Act and this Regulation, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

It was confirmed through interviews and during review of additional information that on this identified date in 2018, PSW #001 left the resident who was at risk for falls unattended and did not stay with the resident and call for assistance by using the call bell to ensure the safety of the resident.
Once the resident was left alone, the resident fell, sustained a serious injury and was hospitalized for an identified period of time.

It was confirmed through interviews, review of the resident's clinical records and review of additional information provided that the licensee failed to ensure that resident #100 was not neglected by the licensee or staff when staff #001 left the resident who was at risk for falls unattended which resulted in a fall with serious injury.

Please note: This area of non-compliance will be issued as a Written Notification (WN) as a compliance order was previously issued during the Resident Quality Inspection (RQI), inspection report #2018_720130_0010 with a compliance due date of February 14, 2019. [s. 19. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A review of the current plan of care for resident #100 indicated that the resident was scheduled to receive a bath or a shower on two identified days of the week. The resident required an identified level of assistance from staff for their bathing.

During an interview with the DNPC, the DNPC indicated that the home had implemented a document titled "Missed Bath List" due to ongoing issues of resident's not receiving their baths. This document was being used to log any missed baths and was to include the reason the bath was missed. If a bath/shower was then provided on another date this date would be also logged.

During review of this document it was identified that on a specific number of identified dates in September and October, 2018, resident #100 did not receive their bath/shower as the unit was short staffed. During interview with PSW staff #004, it was confirmed that baths/showers are missed due to the unit being regularly short staffed.

PSW staff #004 also indicated that this resident was usually only receiving a specific type of bath. During review of the documentation in Point Of Care (POC) for a 30 day look period, it was confirmed that the resident only received a specified bath on an identified date in October, 2018.

It was confirmed through interviews and documentation review that resident #100 was not bathed, at a minimum, twice a week by method of his or her choice.

Please note: This area of non-compliance will be issued as a Written Notification (WN) as a compliance order was previously issued during the Resident Quality Inspection (RQI), inspection report #2018_720130_0010 with a compliance due date of March 30, 2019.
[s. 33. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received fingernail care, including the cutting of fingernails.

It was observed on the identified dates in 2018, that resident #100 had dark debris underneath their fingernails on both hands. A review of the resident's clinical record indicated that the resident required an identified level of assistance for maintaining daily appearance. Identified number of staff to provide personal care.

Resident #100 was scheduled for baths or showers twice per week.

A review of the resident's clinical record indicated that on an identified date during this inspection, PSW #003 signed off in the resident's electronic record that they provided nail care during their bath. The following day, the LTCH Inspector interviewed PSW #003 and they confirmed that they did not provide nail care to resident #100 as documented.

It was confirmed through observations and during interview with PSW staff #003 that resident #100 had not been provided fingernail care. [s. 35. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date in April, 2018, resident #100 fell and was found on the floor of their room by staff as the resident's alarm had been activated. Staff immediately responded to the resident's alarm to assess and assist the resident.

During review of additional information provided during this inspection, it was identified that an identified number of staff members transferred resident #100 back to their bed using a specified lift.

During this inspection this information was reviewed with the CNO and the CNO confirmed that the identified staff lifted the resident off the floor after the unwitnessed fall and that a specified lift should have been used.

Please note: This area of non-compliance will be issued as a Written Notification (WN) as a compliance order was previously issued during the Resident Quality Inspection (RQI), inspection report #2018_720130_0010 with a compliance due date of March 30, 2019. [s. 36.]

Issued on this 15th day of January, 2019

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

Original report signed by the inspector.