Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 15, 2020	2020_704682_0006	002217-20, 003169-20, 010301-20	Critical Incident System

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

AILEEN GRABA (682)

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): June 24, 26, 29, 30, July 6, 7, 8, 9, 2020.

The following Critical Incident System inspections were conducted :
002217-20 related to fall prevention
003169-20 related to prevention of abuse and neglect
010301-20 related to falls prevention

During the course of the inspection, the inspector(s) spoke with Acting Chief Nursing Officer, Associate Director of Nursing (ADON), Hamilton Niagara Haldimand Brant Behavioural Supports Ontario team lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector(s) toured the home, reviewed resident health records, meeting minutes, policies and procedures, program evaluations, staffing schedules, Critical Incident System (CIS) submissions and investigative notes and observed residents and the provision of care.

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

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	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. 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 :

The licensee failed to ensure that all residents were protected from abuse by anyone.

A critical incident was submitted to Director.

A review of resident's #002 care plan identified a focus related to responsive behaviours with interventions in place to minimize the responsive behaviour. A clinical record review included progress notes and responsive behaviour incidents that identified altercations between resident #001 and resident #002. On an identified date, Registered Practical Nurse's (RPN) #108 documentation indicated resident #001 and resident #002 had an altercation. On an identified date, RPN #103 documented another incident. On an identified date, RPN #103 also documented that resident #002 and resident #001 were involved in an altercation.

During an interview staff #109 confirmed that they had documented several altercations between resident #001 and resident #002. During an interview, the Associate Director of Nursing (ADON) stated that they were aware that resident #001 and resident #002 had potential for responsive behaviours and altercations. The home failed to protect resident #001 from physical abuse by anyone. [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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A critical incident was submitted to the Director.

A review of resident's #001 clinical record included a progress note, RPN #101 documented that resident #001 had sustained an injury caused by a co-resident. Further review of the clinical record did not include documentation of the incident that occurred between resident #001 and resident #002. During an interview, RPN #106 indicated that they were required to document altercations in the clinical records of the residents involved. During an interview, ADON #104 acknowledged that the documentation was not done. The ADON confirmed that the home did not ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 written policy to promote zero tolerance of abuse and neglect of residents is complied with, 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. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1.The licensee failed to ensure that, for resident #002 demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

A critical incident was submitted to Director.

A clinical record review included the care plan, resident #002 had a focus for responsive behaviour with interventions to minimize responsive behaviours. A clinical record review included progress notes that identified altercations between resident #001 and resident #002. During an interview staff #109 stated that they reported and met with registered staff to discuss triggers, recommendations and strategies and it was up to the registered staff to include the information into the resident's care plan. During an interview, the ADON #104 stated that additional strategies had not been developed or implemented to respond to resident's #002 ongoing responsive behaviour where possible. [s. 53. (4) (b)]

2. The licensee failed to ensure that for resident #004 demonstrating responsive behaviours, actions were taken to respond to the needs for the resident, including assessments, interventions and the resident's responses to interventions were documented.

A critical incident was submitted to Director.

A clinical record review included resident's #004 care plan that identified a focus for responsive behaviours and interventions to minimize responsive behaviour. A review of resident's #004 clinical record did not include a progress note or responsive behaviour incident related to an altercation that involved resident #002. There was no documented evidence of any assessments, interventions or responses to interventions in relation to resident's #004 needs. During an interview, RPN #106 stated that altercations between residents were documented in the residents clinical record that were involved. During an interview, RPN #101 did not recall the incident involving resident #004. During an interview, the ADON #104 confirmed that the incident occurred between resident #002 and resident #004 was not documented. The ADON acknowledged that RPN #101 failed to ensure that actions taken to respond to the needs for resident #004, including assessments, interventions and the resident's responses to interventions were documented. [s. 53. (4) (c)]

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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they have complied with paragraph 2 of section 24 (1) of the LTCHA related to reporting certain matters to the Director.

Section 24 (1) paragraph 2 of the LTCHA states that "a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident."

Furthermore, section 152 (2) of the LTCHA states that "where an inspector finds that a staff member has not complied with subsection 24 (1) or 26 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate."

A critical incident was submitted to the Director. A review of the investigative notes related to the incident indicated resident #001 had an injury sustained by a co- resident. The ADON stated the incident was not reported immediately to the Director. The home failed to ensure that its duty to report certain matters to the Director under s. 24 (1) of the LTCHA was complied with. [s. 24. (1)]

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.