Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: March 3, 2023

Inspection Number: 2023-1484-0004

Inspection Type:
Follow up
Critical Incident System

Licensee: Albright Gardens Homes, Incorporated

Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville

Lead Inspector	**Inspector Digital Signature**
Sydney Withers (740735)	Sydney Withers Digitally signed by Sydney Withers Date: 2023.03.09 11:32:30 -05'00'

Additional Inspector(s)
Yuliya Fedotova (632)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 26-27, 30-31, February 2-3, 6-9, 13-14, 2023

The following intake(s) were inspected:

- Intake #00016176 was related to falls prevention and management;
- Intake #00018175 was a follow-up related to developing, training staff on and implementing a call bell policy;
- Intake #00018182 was a follow-up related to infection prevention and control;
- Intake #00018176 was a follow-up related to abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
FLTCA, 2021	s. 5	2022-1484-0001	001	Yuliya Fedotova (632)
FLTCA, 2021	s. 24 (1)	2022-1484-0003	001	Yuliya Fedotova (632)
O. Reg., 246/22	s. 272	2022-1484-0001	005	Sydney Withers (740735)

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that on every shift, (a) symptoms indicating the presence of infection in residents were monitored in accordance with any standard or protocol issued by the Director under subsection (2).

Rationale and Summary
A medical report received by the home identified that a resident had an infection. Treatment was ordered on the same day to begin the following day. The resident's clinical records did not include symptom monitoring documentation indicating the presence of infection on three different shifts.

The resident confirmed they were not feeling well and still had pain due to an infection. Registered staff identified that staff referred to an infection in the shift report and to the resident's chart and there was no need to monitor. The resident would tell the staff that they felt unwell.

The Director of Nursing and Resident Care (DONRC) identified that the home's Infection Assessment and Surveillance policy was updated on monitoring the symptoms of infection among residents every shift and the home began registered staff training, which was to be completed by the following month.

Sources: Digital Prescriber's Order, resident clinical records, the updated Infection Assessment and Surveillance Policy (reviewed February 3, 2023), registered staff training records on the updated Infection Assessment and Surveillance Policy; interview with resident and staff. [632]

Date Remedy Implemented: February 12, 2023

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every Minister's Directive that applies to the long-term care home was complied with. The Minister's Directive, specifically the COVID-19 guidance document for long-term care homes in Ontario, specified that homes must ensure general visitors receive and demonstrate a negative test result from a rapid antigen test (RAT) taken at the home prior to entering the home.

Rationale and Summary
The home's policy titled "Rapid Antigen Testing Self Swabbing" indicated a wait period is not required for anyone entering the long-term care home, which was confirmed by the Infection Prevention and Control (IPAC) Lead.

A resident was identified as having additional precautions in place due to close contact with a visitor who entered the home prior to receiving their positive RAT result. The visitor's screening form and visitor log demonstrated that the visitor who tested positive was a general visitor and had not received a RAT at the home one day prior.

Failure to implement the requirement for general visitors to receive and demonstrate a negative test result from a RAT before entering the home placed residents at risk of contracting COVID-19.

Sources: Resident clinical records; resident room observation; Visitor Screening Form; Visitor Log; Policy

#IC 2.1.5 "Rapid Antigen Testing Self Swabbing" (reviewed January 4, 2023); Minister's Directive: COVID-19 guidance document for long-term care homes in Ontario (revised December 23, 2022); interview with IPAC Lead. [740735]

COMPLIANCE ORDER CO #001 Implementation of IPAC Standard

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Ensure all residents with additional precautions in place on two identified units have the required PPE supply available in their PPE caddy.
2. Perform weekly PPE supply audits for four weeks or until compliance is achieved. Document the audits, including the names of staff who completed each audit, the outcome of the audit and any corrective actions taken.
3. Re-train two identified staff on appropriate PPE doffing practices for residents on droplet contact additional precautions. The licensee is to maintain documentation of what education was provided, on what date, and include the signatures of the staff.

Grounds
The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
A. The IPAC Standard for Long-Term Care Homes indicated under section 5.4 that the home's policies and procedures for their IPAC program addressed f) policies and procedures for disease-specific management.

The home's policies and procedures for the IPAC program did not address disease-specific management, which was confirmed by the DONRC and the IPAC Lead.

Sources: McGeers Criteria for Infection Surveillance Checklist, Infection Assessment and Surveillance policy N-9.19 (revised February 3, 2023); interviews with staff. [632]

B. The IPAC Standard for Long-Term Care Homes, indicated under section 6.1 that the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate

to their role and level of risk.

Three resident rooms with additional precautions in place did not have eye protection available in the PPE caddy. A resident was exhibiting respiratory symptoms and their clinical records indicated they were in isolation. Another resident was residing on an outbreak unit and exhibiting respiratory symptoms. In two of the three rooms, staff members were observed within two meters of the residents without eye protection. Two registered staff members stated that all the required PPE should be stocked in the caddy and verified that it was not.

There was an increased risk of infectious disease transmission due to the required PPE not being available for staff at point of care.

Sources: Observations; resident clinical records; interviews with staff. [740735]

C. The IPAC Standard for Long-Term Care Homes indicated under section 9.1 that routine practices were to be followed in the IPAC program which included d) the proper use of PPE, including the appropriate selection and application of PPE.

In the COVID-19 testing trailer, a rapid antigen tester was observed within two meters of a visitor administering a RAT without eye protection. Another rapid antigen tester and the IPAC Lead said testers are expected to wear eye protection when administering a RAT. The home's policy "Personal Protective Equipment" indicated eye protection is worn as part of routine practices to protect the eyes when a procedure is likely to generate sprays of body fluids.

There was minimal risk to the residents, as the rapid antigen testers carry out their job duties in a trailer outside the home and do not enter resident home areas as part of their role.

Sources: Observation of testing trailer; Policy #IC 2.2 "Personal Protective Equipment" (reviewed January 27, 2023); interviews with staff. [740735]

D. The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that routine practices were to be followed in the IPAC program which included b) hand hygiene, including, but not limited to, at the four moments of hand hygiene.

A direct care staff was observed entering a resident's room once and exiting the same room three times without performing hand hygiene before or after resident/resident environment contact. Another direct care staff and the IPAC Lead stated hand hygiene is required prior to entry and after exiting a resident's room.

Failure of staff to complete hand hygiene at the required four moments of hand hygiene increased the risk of infectious disease transmission.

Sources: Observation of resident room; interviews with staff. [740735]

E. The IPAC Standard for Long-Term Care Homes indicated under section 9.1 that additional precautions were to be followed in the IPAC program which included a) and b) evidence-based practices related to potential contact and droplet transmission and required precautions respectively.

A resident's room had additional precaution signage posted which did not include eye protection as required PPE. The resident was isolated for exposure to COVID-19. The home's policy "Personal Protective Equipment", indicated that mask and eye protection were required within two meters of a resident for the additional precautions that were in place. The IPAC Lead verified that the signage was incorrect and did not list eye protection as required PPE.

Failure for the signage to include all evidence-based PPE practices for the additional precautions that were in place increased the risk of infectious disease transmission.

Sources: Observation of resident room signage; resident clinical records; Policy #IC 2.2 "Personal Protective Equipment" (reviewed January 27, 2023); interview with IPAC Lead. [740735]

F. The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that additional precautions were to be followed in the IPAC program which included e) point of care signage indicating that enhanced IPAC control measures were in place.

A resident's room did not have point of care signage indicating additional precautions were in place. They were exhibiting respiratory symptoms and their clinical records indicated they were in isolation. A caddy containing PPE and donning/doffing signage were mounted on the door. A direct care staff member was not aware what additional precautions were required for entering the resident's room. A registered staff member confirmed no signage was present and that additional precaution signage should be in place.

There was an increased risk of infectious disease transmission, as staff demonstrated uncertainty related to PPE required for entering the resident's room.

Sources: Observation of resident room; resident clinical records; interviews with staff [740735]

G. The IPAC Standard for Long-Term Care Homes indicated under section 9.1 that additional precautions were to be followed in the IPAC program which included f) the proper use of PPE including the appropriate selection and application of PPE.

Signage indicated additional precautions were in place for a resident. The resident was exhibiting respiratory symptoms and their clinical records indicated they were in isolation. Direct care and registered staff were observed in the resident's room within two meters of the resident without eye protection donned. They acknowledged that eye protection was not worn and confirmed that it was required.

Failure of staff to select and apply the appropriate PPE when entering a resident room with additional precautions in place increased the risk of infectious disease transmission.

Sources: Observation of resident room; resident clinical records; interviews with staff. [740735]

H. The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that additional precautions were to be followed in the IPAC program which included f) the proper use of PPE including the appropriate removal and disposal of PPE.

i) Signage indicated additional precautions were in place for a resident. The resident was exhibiting respiratory symptoms and their clinical records indicated they were in isolation. Direct care and registered staff were observed exiting the resident's room after being within two meters of the resident, without replacing their medical masks. Additionally, a staff member was observed exiting another resident's room, located on an outbreak unit, who was experiencing respiratory symptoms. They were observed not replacing their medical mask after being within two meters of the resident.

A registered staff and the IPAC Lead stated medical masks were to be changed upon exiting a droplet contact additional precaution room. The home's policy titled "Personal Protective Equipment" included removal and discarding of masks as part of the steps for doffing PPE.

ii) A direct care staff was observed exiting a resident's room twice without removing their gloves, goggles or mask, and walking through the hallway where other residents were present. A registered staff and the IPAC Lead stated these items were to be removed upon exiting a resident's room. The home's policy titled "Personal Protective Equipment" said if a health care provider leaves the room, their PPE must be removed and discarded.

iii) A direct care staff exited a resident's room and was observed doffing their reusable eye protection and placing it back in the PPE caddy without disinfecting it with the available wipes. A registered staff

and the IPAC Lead stated eye protection was to be sanitized upon exiting the resident's room. The home's policy titled "Personal Protective Equipment" stated if eye protection is reusable, it is to be cleaned prior to re-use.

There was an increased risk of infectious disease transmission, as one resident was exhibiting respiratory symptoms at the time of the observation and the second resident was awaiting a COVID-19 test result.

Sources: Observation of resident rooms; resident clinical records for residents; interviews with staff. [740735]

This order must be complied with by April 17, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg. 246/22 s. 102 (2) (b) resulting in a WN in inspection #2022-1484-0001, issued July 6, 2022; a CO (complied) and NCR in inspection #2022-1484-0002, issued August 5, 2022; and one WN in inspection #2022-1484-0003, issued January 12, 2023.

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

Second follow-up to CO #001 / 2022-1484-0001, FLTCA, 2021, s. 5, r/t home developing, training staff and implementing a call bell policy, CDD October 14, 2022, RIF of $500 Second follow-up to CO #005 / 2022-1484-0001, O. Reg. 246/22 s. 272 r/t IPAC, CDD October 14, 2022, RIF of $500

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.