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
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: July 18, 2023

Inspection Number: 2023-1484-0005

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**
Jennifer Allen (706480)	Jennifer L Allen Digitally signed by Jennifer L Allen Date: 2023.07.19 10:22:03 -04'00'

Additional Inspector(s)
Erin Denton-O'Neill (740861)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): **June 28-30, and July 4-7, 10-12, 2023.**

The following intake(s) were inspected:

- Intake: #00001412 - [CI: 2983-000032-22] Physical abuse to a resident by another resident.
- Intake: #00002066 - [CI: 2983-000027-22] Neglect of a resident by staff.
- Intake: #00002555 - [CI: 2983-000034-22] Unexpected death of a resident.
- Intake: #00017384 - [CI: 2983-000001-23] Fall of a resident resulting in an injury.
- Intake: #00022038 - Follow-up to CO #001 O. Reg., s. 102 (2) (b) r/t IPAC Standard, Inspection #2023-1484-0004, CDD: April 17, 2023.
- Intake: #00084600 - [CI: 2983-000014-23] Physical abuse of a resident by another resident.
- Intake: #00086957 - [CI: 2983-000021-23] Unexpected death of a resident.

The following intakes were completed in this inspection: Intake: #00002179 - [CI: 2983-000026-22 and Intake: #00019146 - [CI: 2983-000004-23] were related to an injury with a significant change in condition from a fall.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1484-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Jennifer Allen (706480)

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

- Resident Care and Support Services
- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1).

The licensee has failed to ensure a resident was protected from neglect by the licensee or staff.

Section seven of Ontario Regulation 246/22 defines neglect 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".

Rationale and Summary
A staff member reported they found a resident sitting on the toilet connected to a mechanical lift. The resident's progress notes, and the home's internal investigation notes indicated that the resident was left unattended on the toilet in a mechanical lift.

The home's Zero Tolerance of Abuse policy stated all residents have the right to be free from neglect and abuse. The night shift staff routine stated that residents are to be checked every hour and staff confirmed that residents are to be checked at the beginning and end of every shift and hourly. The home's internal investigation notes and the resident's progress notes confirmed that this was not done. The Director of Nursing and Personal Care confirmed that the home's internal investigation concluded that the PSW did not follow the plan of care when toileting the resident and left the resident in an unsafe situation that put the resident's safety at risk.

Failure to protect the resident from neglect caused potential harm to the resident's health and wellbeing.

Sources: CI report, the home's investigation notes, the resident's progress notes, Zero Tolerance of Neglect and Abuse Policy N-10.11 last revised December 23, 2021, interviews with staff and Director of Nursing and Personal Care.
[740861]

WRITTEN NOTIFICATION: Transferring

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40.

The Licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
According to the home's internal investigation notes, a staff member transferred a resident with the use of a mechanical lift without the assistance of a second staff member. The Director of Nursing and Personal Care confirmed this. The resident's plan of care at the time, required two staff assistance for transferring the resident to a toilet with the use of a mechanical lift.

Failing to ensure that staff used safe transfer techniques posed a significant risk to the resident.

Sources: the resident's plan of care; home's internal investigation notes, interview with Director of Nursing and Personal Care.
[740861]

WRITTEN NOTIFICATION: Skin Assessment

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i).

The licensee failed to ensure that a resident who exhibited altered skin integrity was assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

A resident had an incident and sustained an altered skin integrity injury. At the time of the injury there were no skin assessments using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments completed.

The home's Skin Assessment policy stated that a skin alteration, such as a skin tear, should be assessed utilizing the Weekly Wound Assessment, and the Assessment and Treatment Roles and Responsibilities of Staff policy stated the assessment should be completed upon identification of the wound.

The Associate Director of Nursing and Personal Care (ADON) stated that a weekly wound assessment should have been completed at the time of identification and a subsequent wound assessment should have been completed within seven days of the previous assessment.

Failure to ensure a skin assessment, using a clinically appropriate assessment instrument was completed for the resident when the resident had a change in skin integrity may increase the risk of delay in healing.

Sources: resident's health record; Skin Assessment Policy (N-9.14.4, Last revised April 16, 2020), Assessment and Treatment Roles and Responsibilities of Staff (N-9.14.6, Last revised April 16, 2020); interviews with the ADON.

[706480]