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: December 19, 2023
Inspection Number: 2023-1484-0007
Inspection Type: Complaint Critical Incident
Licensee: Albright Gardens Homes, Incorporated
Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville

Lead Inspector	**Inspector Digital Signature**
Stephany Kulis (000766)	Stephany Kulis Digitally signed by Stephany Kulis Date: 2023.12.22 11:10:11 -05'00'

Additional Inspector(s)
Erika Reaman (000764)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5-8, 14, 2023

The following intake(s) were inspected:

- Intake: #00095303 -Critical Incident (CI) 2983-000031-23 - COVID- 19 Outbreak
- Intake: #00095617 -CI 2983-000032-23 - Fall of resident resulting in injury.
- Intake: #00096229 -CI 2983-000036-23 - Fall of resident resulting in injury.
- Intake: #00101629 - Complainant with concerns for resident regarding plan of care and continence care and bowel management and UTI management.
- Intake: #00102555 -CI 2983-000045-23 - COVID-19

- Intake: #00103365 -CI 2983-000046-23 - Respiratory Outbreak

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there is a written plan of care for a resident that, sets out clear directions to staff and others who provide direct care to a resident.

Rational and Summary
A resident's progress notes indicated that the resident would have a task created for staff to complete a specific care area every hour while they were palliative. Review of the resident's clinical records did not show a task created for this. Interview with a Personal Support Worker (PSW) indicated they were not aware of there being a task

during the time frame discussed.

Sources: complainant phone call, resident clinical records, interview with PSW. [000764]

WRITTEN NOTIFICATION: Protection from certain restraining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.

The licensee has failed to ensure that a resident was not restrained for the convenience of staff.

Rational and Summary
A resident's progress notes indicated that staff tilted their wheelchair after they attempted to stand up. Interview with a Registered Practical Nurse (RPN) indicated that the resident was tilted in their wheelchair to prevent them from rising.

Failing to ensure that the resident was not restrained for the convenience of staff posed a risk of injury to the resident.

Sources: Resident's clinical records, Interview with RPN and other staff. [000764]

WRITTEN NOTIFICATION: Availability of supplies

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The licensee has failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of a resident.

Rational and Summary
A resident's progress notes indicated that there were no catheter supplies present in the home. Interview with a Registered Nurse (RN) confirmed that at the time questioned there were no catheter supplies present in the home.

Sources: Complainant phone call, resident's clinical records, interview with RN. [000764]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure staff recorded symptoms of infection of residents on an outbreak unit.

Rationale and Summary
According to the Infection Prevention and Control (IPAC) Standard section 3, a surveillance protocol is to be used to monitor symptoms of residents with an infection every shift. The line list of the home indicated a few residents in the same home area were in insolation.

Residents' progress notes showed they did not have symptoms monitored and recorded for multiple shifts. IPAC Lead stated monitoring of symptoms for isolated residents on outbreak units are to be done every shift.

Staff failing to document symptoms every shift may cause failure to take immediate action upon change in condition and delay in notification to the interdisciplinary team and POA/SDM.

Sources: Residents' progress notes; Interviews with IPAC Lead and RN; Line list. [000766]