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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Original Public Report

Report Issue Date: October 24, 2024	
Inspection Number: 2024-1484-0003	
Inspection Type: Critical Incident Follow up	
Licensee: Albright Gardens Homes, Incorporated	
Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16-18, 2024

The following intake(s) were inspected:
Intake: #00119744 -Critical Incident (CI) #2983-000023-24 - Physical abuse resident to resident.
Intake: #00120759 - CI #2983-000025-24 - Fall of resident resulting in injury.
Intake: #00122994 -Follow-up #: 1 - O. Reg. 246/22 - s. 102 (8) Compliance Due Date (CDD): September 13, 2024

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1484-0002 related to O. Reg. 246/22, s. 102 (8).

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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 (7)
Plan of care
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.

The licensee has failed to ensure that care was provided to a resident as specified in their plan of care.

Rationale and Summary
On a specific date in 2024 a resident sustained a fall that resulted in an injury requiring repair. Review of the resident's clinical records indicated they were to have a falls intervention in place and on at all times when the resident was in bed. The home's investigation notes related to the fall showed that the resident's falls

intervention was not functioning at the time of the fall, and did not alert staff that the resident had gotten out of bed. Documentation reviewed regarding resident's falls intervention the night of fall indicated 'not applicable.

The Associate Director of Care (ADOC) confirmed that there was no record of the resident's falls intervention alerting the night of the fall, and indicated it was not connected at time of the fall.

Failure of the home to provide care to the resident as specified in their plan of care led to risk of resident's safety resulting in injury.

Sources: Resident's clinical records, interview with staff ADOC.

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to protect a resident from abuse from another resident.

Ontario Regulation (O. Reg.) 246/22 defines "physical abuse" as (c) the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
On a specific date in 2024 the home reported an incident of abuse. Two residents had a verbal altercation and one resident used physical force to the other resident.

This resulted in injury to the other resident.

The Associate Director of Care (ADOC) confirmed that the resident received a physical injury from the physical force used by the other resident.

The resident's safety and well-being were impacted when they were not protected from abuse by another resident.

Sources: Resident's clinical records, resident's physical records, Critical Incident Report 2983-000023-24, Interview with ADOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident received a skin assessment after returning from hospital admission.

Rationale and Summary
A resident had a fall resulting in injury requiring repair. The resident's clinical records at the home did not show a skin assessment completed for the resident upon their return from hospital. The home's policy titled "Skin and Wound Care Program", indicated that a resident at risk of altered skin integrity will receive a skin

assessment by a member of the Registered nursing staff upon readmission from the hospital.

Register staff confirmed that there was no skin assessment completed for the resident upon readmission from hospital.

By not completing a skin assessment on the resident it posed a risk of not identifying a worsening skin condition.

Sources: Resident's clinical records, home's policy titled "Skin and Wound Care Program", last reviewed August 9, 2024, interview with Registered staff.