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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 15, 2025
Original Report Issue Date: March 14, 2025
Inspection Number: 2025-1484-0003 (A1)
Inspection Type: Critical Incident
Licensee: Albright Gardens Homes, Incorporated
Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order #001/Non-Compliance #009 related to FLTCA 2021, s. 24 (1) issued on March 14, 2025, was amended to rescind an AMP. The AMP was replaced by a Director AMP issued on April 15, 2025 following a Director Review.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4-7, 2025 and March 10-12, 2025
The inspection occurred offsite on the following date(s): March 6, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intake #00130733/CI #2983-000031-24 - related to prevention of abuse and neglect
- Intake #00131855/CI #2983-000032-24 - related to prevention of abuse and

neglect
- Intake #00132222/CI #2983-000033-24 - related to falls prevention and management
- Intake #00134041/CI #2983-000037-24 -related to prevention of abuse and neglect
- Intake #00137740/CI #2983-000002-25 - related to falls prevention and management
- Intake #00136053/CI #2983-000001-25 - related to infection prevention and control

The following CI intake(s) were completed:
Intake #00135753/CI #2983-000039-24 - related to infection prevention and control
Intake #00133184/CI #2983-000035-24- related to infection prevention and control

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED 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.

A) The licensee has failed to ensure that an intervention set out in a resident's plan of care was carried out as prescribed in the plan. The resident's written plan of care had an intervention to mitigate responsive behaviours towards co-residents. During separate observations on one date, the intervention was not implemented.

Sources: Observations; a resident's plan of care and staff interview.

B) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to them as specified in their plan. The resident's plan of care indicated they required frequent monitoring. A review of the resident's documentation indicated they were not monitored as required on specified dates.

Sources: A resident's clinical records.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with when an assessment was not completed on a resident. The home's Zero Tolerance of Abuse and Neglect policy

stated that in a case of an alleged incident of abuse, staff were to conduct an assessment on the alleged victim and document findings. A review of a resident's clinical record did not generate information to support that an assessment was completed and staff confirmed it had been missed.

Sources: The home's Zero Tolerance of Abuse and Neglect policy, a resident's clinical records, and staff interview.

WRITTEN NOTIFICATION: Written Notification pursuant to O. Reg. 246/22 s. 54 (2) in reference to O. Reg 246/22 s. 11 (1) (b) related to falls prevention and management program.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a fall follow-up assessment was completed at specified intervals, as required, for a resident that sustained a fall.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the Fall Prevention and Management Program is complied with.

Specifically, the staff did not comply with the Falls Prevention and Management Program: Post Fall Assessment policy when staff completed the initial follow-up fall assessment several hours after it was required after the resident fell.

Sources: The home's Falls Prevention and Management Program: Post Fall Assessment policy; a resident's clinical record; interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's wound was re-assessed at least weekly by a member of the registered nursing staff. The resident's clinical record did not include information to support that weekly skin and wound care assessment was provided to maintain their skin integrity, after they sustained an injury. This was acknowledged by staff.

Sources: A resident's clinical record and staff interview.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

A) The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

The IPAC Standard for Long-Term Care Homes revised September 2023, s. 9.1 (d) states the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program, specifically proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

A staff member was observed entering a resident's room without any personal protective equipment on. Additional precaution signage on the resident's door instructed staff to donn specific PPE before entering the room.

Management stated when staff go into an additional precautions isolation room, they are required to wear the appropriate PPE.

There was risk of transmitting infection when staff did not donn PPE when entering an additional precautions isolation room.

Sources: Observations of PPE donning/doffing; the home's Management of Residents with Respiratory Symptoms Chart; the home's Contact Precautions policy; interviews with staff; a resident's plan of care.

B) The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

The IPAC Standard for Long-Term Care Homes revised September 2023, s. 9.1 (d) states the licensee shall ensure that routine practices and additional precautions are

followed in the IPAC program, specifically proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

A resident was placed on additional precautions isolation for symptoms of infection. A staff member indicated they entered the resident's room wearing a surgical mask instead of an N95 mask.

The home's Droplet-Contact Plus Precautions policy stated staff providing direct care to a resident with suspected or confirmed Covid-19 or other respiratory illness must wear an N95 mask, eye protection, gowns, and gloves until the organism is identified.

There was risk of transmitting infection with staff did not donn an N95 mask when entering an additional precaution isolation room.

Sources: The home's Management of Residents with Respiratory Symptoms Chart; the home's Droplet-Contact Plus Precautions policy; a resident's plan of care; interviews with staff; observations of isolation signage on a resident's doorway.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that a staff member complied with the infection prevention and control program when they removed a meal tray from an additional precaution isolation room, placed it on the snack cart, and continued serving co-residents on a specified date. Management stated that trays should not be coming out of isolation rooms and should be disposed of in the garbage can. They also stated if a tray is not disposable then it should be collected from an isolation room last.

There was risk of transmitting infection when staff did not remove a tray from an isolation room as per policy.

Sources: Observations of a resident's room; the home's Guidelines for Dietary Infection Control policy; interview with staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

A) The licensee has failed to ensure that a resident and their substitute decision maker (SDM) were made aware of the results of an investigation of an alleged incident of physical abuse. A review of the resident's clinical record showed that their SDM was immediately informed of the alleged incident, however there was no information to support that when the home completed their internal investigation the resident or their SDM were updated.

Sources: The home's internal investigation notes and a resident's clinical record.

B) The licensee has failed to ensure that a resident and their substitute decision maker (SDM) were informed of the results of an investigation regarding the allegation of physical abuse. A review of the resident's clinical record showed that their SDM was immediately informed of the alleged incident, however there was no information to support that when the home completed their internal investigation, the resident or their SDM were informed.

Sources: A resident's clinical record and the home's internal investigation notes.

WRITTEN NOTIFICATION: Resident records

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date following an incident of alleged abuse.

On a specified date a resident used physical force on another resident. A review of a resident's written record showed no documentation related to the incident. Management confirmed there was no documentation related to the incident and that because the resident was involved in an incident, there should have been documentation.

Sources: Interview with management; a resident's clinical record; another resident's clinical record; the home's Responding to a Responsive Behaviour Incident policy,

last reviewed August 9, 2024; the home's Zero Tolerance of Neglect and Abuse policy, last reviewed August 9, 2024.

(A1)

The following AMP(s) related to CO #001 has been rescinded: AMP #001

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

1) Complete a review of two resident's behaviours focus in their plan of care. Reassess the interventions related to responsive behaviors and ensure that all interventions are implemented by staff.

2) Complete an audit to evaluate the effectiveness of the responsive behaviour interventions for each resident. The audits should be completed at least weekly for a minimum of four weeks, and it should include the dates when the audits were completed, the person who completed the audits, the results of the audits, and any actions taken. A record of the audits must be available for inspectors upon request.

Grounds

The Ontario Regulation 246/22, states that physical abuse is the “the use of physical force by a resident that causes physical injury to another resident.”

A) The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Clinical records indicated that a resident sustained an injury when another resident used physical force during a physical altercation. This was acknowledged by staff.

Failure to protect a resident from physical abuse resulted in risk to their safety.

Sources: The residents' clinical record; the home's internal investigation notes and staff interview.

B) The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

A resident entered into another resident's room, resulting in one resident using physical force on the other resident when they were going through their belongings. Clinical records indicated that the resident sustained an injury as a result of the incident. Staff acknowledged that physical abuse was constituted.

Sources: A resident's clinical records; and staff interview.

C) The licensee has failed to ensure that a resident was protected from physical abuse by another resident when the resident used physical force which resulted in a fall with injury.

On a specified date, staff stated they witnessed a resident walk towards them and use physical force on another resident while they were assisting them. The act resulted in the resident falling and sustaining injuries.

Failure to protect a resident from physical abuse resulted in a risk to their safety.

Sources: Interviews with staff; a resident's clinical record; the home's investigation notes.

This order must be complied with by April 25, 2025

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

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.