

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: August 1, 2024	
Inspection Number: 2024-1484-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Albright Gardens Homes, Incorporated	
Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville	
Lead Inspector Nishy Francis (740873)	Inspector Digital Signature
Additional Inspector(s) Erika Reaman (000764)	

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8 - 12, 15, 16, 2024

The following intake(s) were inspected:

- Intake: #00109336 (CI #2983-000008-24) related to falls prevention and management.
- Intake: #00110417 (CI #2983-000011-24) (CI #2983-000012-24) related to infection prevention and control.
- Intake: #00113925 (CI #2983-000015-24) related to infection prevention and control.
- Intake: #00116854 Complaint regarding heating and cooling.

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The following Inspection Protocols were used during this inspection:

Safe and Secure Home  
Infection Prevention and Control  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Cooling Requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 23 (2) (b)

Cooling requirements

s. 23 (2) The heat related illness prevention and management plan must, at a minimum,

(b) identify symptoms of heat related illness and require staff to regularly monitor whether residents exhibit those symptoms and take appropriate actions in response;

The licensee has failed to ensure that the Heat Related Illness Prevention and Management Plan (HRIPMP) identified symptoms of heat related illness.

#### Rationale and Summary

The home's HRIPMP dated April 1, 2024 last revised June 19, 2024 did not identify symptoms of heat related illness. An interview with the home's Administrator #007 confirmed that this was not included in the plan.

Failure to include symptoms of heat related illness in the HRIPMP had risk for not recognizing symptoms of heat related illness in residents.

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Sources: Review of the home's policy titled "Heat Contingency Policy", Interview with Administrator. [000764]

## WRITTEN NOTIFICATION: Cooling Requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 23 (2) (e)

Cooling requirements

s. 23 (2) The heat related illness prevention and management plan must, at a minimum,

(e) include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. O. Reg. 246/22, s. 23 (2); O. Reg. 66/23, s. 3 (1).

The licensee has failed to ensure that the home's Heat Related Illness Prevention and Management Plan (HRIPMP) included a protocol for appropriately communicating the HRIPMP to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate.

### Rationale and Summary

The home's HRIPMP dated April 1, 2024 last revised June 19, 2024, did not identify a protocol for appropriately communicating the HRIPMP to residents, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate.

An interview with the home's Administrator confirmed that a communication protocol is not in place for the resident's and families in relation to the home's

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HRIPMP.

Failure to ensure that there was a protocol in place for communicating the home's HRIPMP led to a risk of miscommunication of what is included in this plan.

Sources: Review of the home's policy titled "Heat Contingency Policy", Interview with Administrator. [000764]

## 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) (b) (i)

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,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment that was exhibiting altered skin integrity.

### Rationale and Summary

On an identified date, a resident sustained a fall with injury and sustained altered skin integrity. The resident's clinical records did not show a skin assessment completed for the resident. The home's policy titled "Skin Assessment, last reviewed April 20, 2024, indicated that skin alterations would be assessed utilizing the weekly wound assessment.

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A staff confirmed that new altered skin integrity would require a skin assessment and acknowledged this was not completed for the resident.

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 Assessment", last reviewed April 20, 2020, interview with staff. [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 (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).

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

### Rationale and Summary

The IPAC lead has failed to ensure that following the resolution of an outbreak, a summary of findings was created that made recommendations to the licensee for improvements to outbreak management practices in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, a summary of findings was not created after a gastrointestinal outbreak in March 2024 and a respiratory outbreak in April 2024 that made recommendations to the licensee for improvements to outbreak

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management practices as is required by Additional Requirement 4.3 under the IPAC Standard. The IPAC lead stated the home discussed IPAC practices that were effective and ineffective in the management of both outbreaks.

When a summary of findings pertaining to IPAC practices that were effective and ineffective in the management of the outbreak was not created, there is risk of ineffective outbreak management practices carried forward to future outbreaks.

Sources: Interview with IPAC lead. [740873]

## WRITTEN NOTIFICATION: Medication Management System

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

A) The licensee has failed to comply with their medication management system to process physician orders for a resident.

### Rationale and Summary

The home's nurse practitioner ordered a specimen sample collection on an identified date. The order was not processed until the following day.

The home's policy titled Doctor's Orders, revised June 1, 2017, stated orders were to be transcribed by a nursing staff to ensure accurate follow-through. A second check was to be completed by a nursing staff on the same shift or the shift immediately

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following.

The DOC stated physician orders were to be processed in 24 hours by nursing staff. A staff stated physician and nurse practitioner orders were routinely left without processing for over one day. They acknowledged risk of harm to the resident when medical orders were not processed in a timely manner.

There was risk of harm to the resident's health when a physician or nurse practitioner's order was not processed in a timely manner. The delay in processing has potential impact to a resident's health and safety as they wait for treatment based on test results.

Sources: Review of resident's clinical record, home's policy titled Doctor's Orders, revised June 1, 2017; interview with staff, and Director of Care.

B) The licensee has failed to comply with their medication management system to process physician orders for a resident.

#### Rationale and Summary

The home's nurse practitioner ordered a specimen sample collection on an identified date. The order details were not documented in the residents clinical record or plan of care.

The home's policy titled Laboratory - Diagnostic Testing, revised July 1, 2024, stated nurses were to process the physician's order in the resident record, complete all required supplier requisitions, and document the tests ordered in the electronic medication administration record with the date of the order. The DOC acknowledged the specimen collection was not documented in the electronic record and should have been.

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There was risk of harm to the resident's health and safety when physician or nurse practitioner orders were not processed as per policy in a timely manner as this resulted in delayed processing of orders.

Sources: Resident's clinical record, home's policy titled Laboratory - Diagnostic Testing, revised July 1, 2024; interviews with Director of Care. [740873]

## COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

1. Educate nursing staff to send stool specimens for laboratory testing when they identify symptoms of Clostridium Difficile Infection as per the home's policy related to Clostridium Difficile Infection Management; and
2. Document the education, including the dates, names of staff receiving education, and the staff member(s) who provided the education; and
3. Keep a record of the documentation of the education for inspector review.

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## Grounds

The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program.

In accordance with O. Reg 246/22, s.11 (1) (b), the licensee was required to ensure that the policies specific to infection prevention and control were complied with.

A) The licensee has failed to comply with policies specific to diagnostic testing for infectious diseases.

## Rationale and Summary

On an identified date, the home's nurse practitioner (NP) ordered a sample collection for a resident as they experienced symptoms of an infection. The NP indicated that the resident was symptomatic for a week.

A staff confirmed the specimen was collected five days after the order was written and stated the sample should have been collected the same day the order was written or the next day.

The home's policy titled Laboratory – Diagnostic testing stated registered staff were to process the physician or nurse practitioner's orders and assign the collection of urine and stool specimens to a PSW.

The specimen was positive for infection, and the resident was prescribed treatment for 10 days. The resident started treatment for the infection one week after the specimen collection was ordered.

There was significant impact to the resident's health, safety, and quality of life when specimen collection was delayed which in turn delayed identification of the

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infection and prevented the resident from receiving earlier treatment. There was actual risk to the resident's health when the home delayed the collection of the specimen to determine whether any action was required.

Sources: Interview with staff; resident's clinical record, home's policy "Laboratory - Diagnostic Testing", last revised July 1, 2024, home's outbreak line list. [740873]

B) The licensee has failed to comply with their infection management policy.

#### Rationale and Summary

The home's policy titled Clostridium Difficile Infection Management, last reviewed March 22, 2024, stated that registered nursing staff were to send stool specimens for testing when they identified symptoms of Clostridium Difficile such as loose/watery stool. Staff and the IPAC lead stated they required an order from the homes physician or nurse practitioner to collect a stool specimen. The DOC stated staff could obtain a specimen without the physician or NP order and send a stool sample when a resident had loose/watery stool.

There was actual risk of infection transmission between residents when the home failed to comply with their infection management policy. The home failed to obtain a specimen and send a stool sample when residents had loose/watery stool. The home declared a Clostridium Difficile outbreak on March 1, 2024, which ended April 1, 2024. There was actual risk of harm to a resident's health when specimen collection for symptoms of an infection did not occur when the resident experienced symptoms.

Sources: Interview with staff, IPAC lead, Director of Care; review of the resident's clinical record, home's policy titled Clostridium Difficile Infection Management (CDI), last reviewed March 22, 2024, home's outbreak line list. [740873]

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C) The licensee has failed to comply with policies specific to diagnostic testing for infectious diseases.

#### Rationale and Summary

On February 21, 2024, the local Public Health unit informed the home of a resident's critical laboratory result. The home did not phone or fax critical results to the physician or nurse practitioner immediately upon receipt for appropriate treatment orders as per the home's policy titled Laboratory – Diagnostic testing.

The following day the physician's progress note stated that they were not informed of a critical laboratory result. The physician ordered an antibiotic treatment when they were made aware of the result.

The IPAC lead and staff could not verify the physician or NP had been contacted. Staff acknowledged the physician or NP should have been contacted immediately.

There was risk of harm to the resident's health, safety and well-being when a physician or nurse practitioner was not informed of critical results as this resulted in a delay in treatment and other actions required.

Sources: Interview with IPAC lead, staff; resident's clinical record and home's policy "Laboratory - Diagnostic Testing", last revised July 8, 2024. [740873]

This order must be complied with by September 13, 2024

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## 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, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3

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e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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:



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

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

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).