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
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Original Public Report

Report Issue Date: January 11, 2023	
Inspection Number: 2022-1484-0003	
Inspection Type: Other Critical Incident System	
Licensee: Albright Gardens Homes, Incorporated	
Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville	
Lead Inspector Angela Finlay (705243)	**Inspector Digital Signature** Angela Finlay Digitally signed by Angela Finlay Date: 2023.01.18 11:59:05 -05'00'
Additional Inspector(s) Lesley Edwards (506) Lisa Vink (168)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 29-30, December 2, December 5-9, 2022, with December 9, 2022 conducted off site.

The following intake(s) were inspected:

- Intake #00003625 (Follow-up) related to staffing.
- Intake #00002072 (Follow-up) related to staffing.
- Intake #00002412 (Follow-up) related to call bells.
- Intake #00002128 (Follow-up) related to abuse.
- Intake #00002604 (Follow-up) related to abuse.
- Intake #00002605 (Follow-up) related to infection prevention and control.
- Intake #00005461 (Follow-up) related to infection prevention and control.
- Intake #00001433 (CI: 2983-000025-22) related to resident-to-resident abuse.
- Intake #00008073 (CI: 2983-000043-22) related to resident-to-resident abuse.
- Intake #00010786 (CI: 2983-000046-22) related to resident-to-resident abuse.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s. 31. (3)	2021_916168_0011	CO #001	Lisa Vink (168)
O. Reg. 246/22	s. 11 (1) (b)	2022_1484_0001	CO #002	Lisa Vink (168)
LTCHA, 2007 and FLTCA, 2021	s. 19 (1) and s. 24 (1)	2022_1484_0001	CO #003	Lesley Edwards (506)
FLTCA, 2021	s. 28 (1) (2)	2022_1484_0001	CO #004	Lesley Edwards (506)
O. Reg. 246/22	s. 102 (2) (b)	2022_1484_0002	CO #001	Angela Finlay (705243)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
FLTCA, 2021	s. 5	2022_1484_0001	CO #001	Lisa Vink (168)
O. Reg. 246/22	s. 272	2022_1484_0001	CO #005	Angela Finlay (705243)

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

Prevention of Abuse and Neglect
Infection Prevention and Control
Food, Nutrition and Hydration
Resident Care and Support Services
Staffing, Training and Care Standards
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that they implemented any standard issued by the Director with respect to IPAC.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, dated April 2022, identified under section 10 Hand Hygiene, the additional requirement of 10.4 items (h) and (i) that the licensee ensure the hand hygiene program included policies and procedure and support for residents to perform hand hygiene prior to receipt of snacks; and support for residents who had difficulty completing hand hygiene due to mobility, cognitive or other impairment.

On two different dates in November, 2022, a dietary aid was observed to distribute morning nourishments to residents on the north/east side of the second floor. The staff member was not observed to support residents to perform hand hygiene prior to receipt of the snacks. The staff member confirmed they were aware of the requirement to support residents with hand hygiene prior to snacks; however, the care was not provided due to an oversight.

The home's Hand Hygiene Process for Residents, identified that hand hygiene support was to be provided to residents by staff prior to snacks with an alcohol-based hand wipe or rub to sanitize their hands.

Failure to provide hand hygiene to residents presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of morning nourishments, review of Hand Hygiene Process for Residents, dated August 11, 2022, and interviews with a dietary aid and other staff. [168]

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to two residents under the

nutritional care and hydration program, as well with respect to a resident under the responsive behaviours program, including interventions and the resident's responses to interventions, were documented.

Rationale and Summary

A) The home offered a between meal beverage in the morning and afternoon and in the evening after dinner.

The October and November 2022, Point of Care (POC) documentation for a resident's fluid intake at nourishment identified 19 occasions where there was no documentation related to the nourishment offered or consumed and 31 occasions where staff documented "not applicable".

Failure to record the intervention and the resident's response had the potential for assessments related to nutrition and hydration to be incomplete or inaccurate.

Sources: Observation of morning nourishment pass, review of clinical health records for the resident and interviews with staff including a dietary aid. [168]

B) The home offered a between meal beverage in the morning and afternoon and in the evening after dinner.

The October and November 2022, POC documentation for another resident's fluid intake at nourishment identified five occasions where there was no documentation related to the nourishment offered or consumed and 32 occasions where staff documented "not applicable".

Failure to record the intervention and the resident's response had the potential for assessments related to nutrition and hydration to be incomplete or inaccurate.

Sources: Observation of morning nourishment pass, review of clinical health records for the resident and interviews with staff including a dietary aid. [168]

C) In response to responsive behaviours a resident was exhibiting, they were started on specific monitoring several times from August until November, 2022. The intention of this intervention was for staff to identify any observed behaviours the resident was exhibiting and document this.

The monitoring was not documented in full on 12 of the expected dates.

Failing to fully document the monitoring may have impaired the home's ability to accurately assess the resident's behaviours.

Sources: The resident's clinical records; and interviews with a personal support worker (PSW) and registered practical nurse (RPN). [705243]

D) A nightly monitoring was initiated for a resident in August, 2022 and was ongoing at time of inspection. This was started in order for staff to better determine how much sleep the resident was getting as this could have contributed to their responsive behaviours.

This was not documented in full for 79 out of the 98 days it was expected to be completed.

Failing to fully document the nightly monitorig may have impaired the home's ability to accurately assess the resident's sleep needs.

Sources: The resident's clinical records; and interviews with a PSW and a RPN. [705243]

WRITTEN NOTIFICATION: Bathing

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that three different residents were bathed by the method of their choice, unless contraindicated by a medical condition.

Rationale and Summary

A) The plan of care for the first resident identified they preferred a tub bath.

The October and November 2022, POC bathing records identified their substitute decision maker requested that the resident receive a tub bath at least one of the two baths per week, otherwise a shower. The POC records identified that during the identified time period the resident received a bed bath on three occasions.

Failure to provide bathing by the preferred method had the potential for resident dissatisfaction.

Sources: Review of bath schedule, observation and clinical record of the resident, and interviews with a PSW and other staff. [168]

B) The plan of care for the second resident identified they preferred a shower.

The October and November 2022, POC bathing records were incomplete for bathing activities on three dates, and identified the resident received a bed bath on two occasions during the time period.

There was no documentation of an as needed shower in the POC records or progress notes. The Missed Bath List identified the resident missed a shower in October with the plan to make up the shower when full staffed; however, there was no documentation that the care was provided.

The DOC confirmed the bathing records did not indicate if bathing was provided on the three identified dates.

Failure to provide bathing twice a week and by the preferred method had the potential for resident dissatisfaction.

Sources: Review of bath schedule and Missed Bath List, observations and clinical record review for the resident, and interviews with a PSW and other staff. [168]

C) The plan of care for the third resident identified they preferred a shower.

The October and November 2022, POC bathing records identified the resident received a bed bath on three occasions.

Failure to provide bathing by the preferred method had the potential for resident dissatisfaction.

Sources: Review of bath schedule, observation and clinical record of the resident, and interviews with a PSW and other staff. [168]

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (2) (b)

The licensee failed to ensure that all interventions used to prevent, minimize or respond to responsive behaviours for a resident, were based on the assessed needs of the resident.

Rationale and Summary
After an incident with other residents, the resident was admitted to hospital in September, 2022. Upon the resident's return from hospital, the home initiated a specific intervention to manage the resident's behaviours.

After the resident had a health consultation, it was noted under impressions that the resident's behaviour had been somewhat more manageable since discharge from hospital but that this improvement was likely only due to the implementation of the specific intervention implemented to manage their behaviours. This specific intervention was then discontinued the next day after the health consultation. There were no assessments or notes in the resident's plan of care that indicated why this was discontinued.

During separate interviews with a PSW and a RPN who were familiar with the resident, they both had indicated they were unaware why the intervention was discontinued and that they believed the resident would benefit from this still being in place. Upon discussion with the DOC, they stated the intervention was discontinued as they felt it was no longer necessary, that this was not based on a documented assessment and after reviewing the resident's current notes stated they would be re-initiating the intervention due to ongoing behaviours.

Removing the specific intervention without a supportive assessment may have placed the other residents at risk.

Sources: The resident's clinical records; and interviews with a PSW, a RPN, and the DOC. [705243]

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)

The licensee failed to ensure that for a resident who had responsive behaviours, their behavioural triggers were identified.

Rationale and Summary
The resident had a history of responsive behaviours.

The resident was admitted to hospital in September, 2022 and was seen by the hospital's Behavioural Supports Ontario (BSO) program. This BSO program had identified several potential triggers for the resident.

This information was not updated into the resident's plan of care at the home, there was no easily accessible information for staff on the resident's triggers and upon interviews with staff, they were unable to identify any of these as triggers for the resident's behaviour.

Failing to identify potential triggers for the resident's responsive behaviours may have impaired the staffs ability to deescalate behaviours and prevent further incidents.

Sources: The resident's clinical records; and interviews with a PSW, a RPN and the DOC. [705243]

WRITTEN NOTIFICATION: Licensee must comply

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee failed to comply with Compliance Order (CO) #001 from Inspection #2022_1484_0001 served on July 6, 2022, with a compliance due date of October 14, 2022.

Rationale and Summary
The conditions of CO #001 cited under the Fixing Long-Term Care Act (FLTCA), 2021, section (s.) 5, specifically related to the home developing, training staff and implementing a call bell policy, was not complied.

i. The licensee failed to develop and implement a policy and procedure related to responding to resident call bells that included a safe time period from the activation of the call bell and staff's response to the call, and directions staff were to follow at all times when the full complement of staff was not present on the home area.

ii. Education on the policy and procedure related to responding to call bells was not completed by two staff who regularly worked on the five north/east home area and by three staff who worked on the home area pursuant to a contract with an employment agency, at the time of the inspection. Twenty-one staff completed the required education after the compliance due date.

iii. A plan of action was not developed and/or implemented when staff failed to comply with the policy and procedure.

Sources: Review of Resident Call Bell System policy and procedure - N-10.13 - dated August 2022, review of call bell audits and Call Bell Analysis records, review of Surge training records and staff lists for agency staff and interviews with the Director of Care (DOC) and other staff. [168]

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
Within the last 36 months, one CO was issued to FLTCA, 2021, s. 5, issued on July 6, 2022, during inspection #2022_1484_0001.

This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Licensee must comply

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee failed to comply with CO #005 from Inspection #2022_1484_0001 served on July 6, 2022, with a compliance due date of October 14, 2022.

Rationale and Summary
The conditions of CO #005 cited under the Ontario Regulation (O. Reg.) 246/22, s. 272, specifically related to auditing staff's Coronavirus-19 (COVID-19) surveillance testing, was not complied.

The licensee failed to maintain a record of weekly audits including any corrective actions or follow-ups taken as a result of the audits, to ensure staff were complying with the COVID-19 surveillance testing requirements as per the "COVID-19 guidance document for long-term care homes in Ontario."

Sources: CO #005 from #2022_1484_0001; and interview with the infection prevention and control (IPAC) lead and the DOC. [705243]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #007
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
Within the last 36 months, one CO was issued to O. Reg. 246/22, s. 272, issued on July 6, 2022, during inspection #2022_1484_0001.

This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

Specifically, the licensee must:

1. Protect residents #014 and #015 from abuse from resident #012.

2. Review and where necessary revise the care plan for resident #012, related to their responsive behaviours, to ensure that strategies are developed, in place, current and clearly communicated to manage their care needs and reduce risk to co-residents. A written record of the changes must be maintained and available on request.

Grounds
The licensee failed to ensure that they protected resident #014 and #015 from abuse by anyone.

Rationale and Summary
O. Reg. 246/22 s. 2. (1) identified for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, “physical abuse” was defined as the use of force by a resident that caused physical injury to another resident.

According to a PSW who worked the night of the incident, they noted resident #012 was not in their bed. They immediately initiated a search for the resident, who had a history of responsive behaviours. During the search residents #014 and #015 were found on the floors in their bedrooms. Resident #012 was found in the bedroom of another resident. The PSW and other staff had arrived to provide assistance and resident #012 was removed from the other resident’s room.

A review of the progress notes and assessments for residents #014 and #015 related to the incident identified involvement by resident #012; and that resident’s #014 and #015 sustained injuries.

The DOC, who submitted a Critical Incident (CI) report for abuse of a resident that resulted in harm or risk of harm to a resident, confirmed the incident was physical abuse by resident #012 to residents #014 and #015.

Failure to protect resident #014 and #015 from abuse by resident #012 resulted in physical injury to the residents.

Sources: Review of clinical health records of resident #013, #014 and #015 and CI Report 2983-000043-22, and interviews with the PSW and other staff. [168]

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
hamiltondistrict.mltc@ontario.ca

This order must be complied with by: January 24, 2023

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.