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

Original Public Report

Report Issue Date: September 18, 2023
Inspection Number: 2023-1484-0006
Inspection Type: Critical Incident
Licensee: Albright Gardens Homes, Incorporated
Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville

Lead Inspector	**Inspector Digital Signature**
Erika Reaman (000764)	Erika Reaman Digitally signed by Erika Reaman Date: 2023.09.19 13:20:35 -04'00'

Additional Inspector(s)
Brittany Wood (000763)

INSPECTION SUMMARY

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

The following intake(s) were inspected:

- Intake: #00090909 -Critical Incident (CI) 2983-000024-23 - Resident to resident physical abuse.
- Intake: #00091584 -CI 2983-000025-23 - Fall of resident resulting in injury.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that, for each resident demonstrated responsive behaviours, strategies are implemented to respond to these behaviours, where possible.

Rationale and Summary

A responsive behaviour assessment was completed for a resident that indicated, they will get upset if unwanted co-residents go in their room. Their plan of care indicated that an intervention was to be in place, to prevent from wandering behaviours. During inspection the resident was observed in their room with no intervention present.

Staff acknowledged that there was no intervention present. Staff identified that the intervention was effective for wandering behaviours.

Failure to ensure the intervention was in place increased the risk that the resident would have responsive behaviours.

Sources: Resident's clinical records, observations, and interviews with staff.

[000763]