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

Public Report

Report Issue Date: May 29, 2025
Inspection Number: 2025-1484-0004
Inspection Type: Complaint Critical Incident Follow up
Licensee: Albright Gardens Homes, Incorporated
Long Term Care Home and City: Albright Gardens Homes, Incorporated, Beamsville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 20, 22, 23, 26, 27, 28, 29, 2025.

The following intake(s) were inspected:
· Intake: #00142469 -Follow up inspection related to Duty to Protect.
· Intake: #00144849 – Critical Incident System (CIS) #2983-000006-25 - related to infection prevention and control.
· Intake: #00146743 – CIS #983-000008-25- related to fall prevention and management.
· Intake: #00147104 – complaint related to allegation of neglect and resident care and support services.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1484-0003 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the physiotherapy assessment and transfers and repositioning assessment for a resident were consistent and complemented each other, when one assessment indicated the resident could not weight bear, and the second assessment indicated the resident could stand.

Sources: a resident's assessment records, plan of care, and interviews with the Physiotherapist; Director of Programs and other staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug prescribed for a resident was administered in accordance with the directions for use specified by the prescriber, for an undetermined period of time, on a specified date.

Sources: a resident's progress notes, plan of care, physician orders and an interview with the Assistant Director of Care.