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
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Public Report

Report Issue Date: August 8, 2025
Inspection Number: 2025-1484-0005
Inspection Type: Critical Incident
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): July 31, 2025, and August 1, 5, 6, 7, 8, 2025

The following intake(s) were inspected:

- Intake: #00147154/ Critical Incident (CI) #2983-000009-25 related to fall prevention and management.
- Intake: #00151729/ CI #2983-000010-25 - related to prevention of resident abuse and neglect.

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

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to protect a resident from physical abuse by another resident.

Section 2 of Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On a specified date, a resident entered another resident's room, kicked the home staff present in the room, and physically dragged the resident to the floor mat. The home staff intervened to separate the residents. The affected resident sustained an injury and required ongoing assessment and monitoring. The initiating resident had a history of responsive behaviours and required the implementation of a specialized intervention to maintain a safe environment for others.

The Director of Care (DOC) acknowledged that one resident physically abused another resident, and reported that the specialized intervention for resident with responsive behaviours was not implemented at the time of the incident.

Sources: Resident Clinical Records, Home's Internal Investigation Notes, Interview with the home staff, and the DOC.