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 26, 2025
Inspection Number: 2025-1384-0002
Inspection Type: Critical Incident
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.
Long Term Care Home and City: AgeCare Brant, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13-16, 21-23 and May 26, 2025.

The following intake(s) were inspected:

- Intake: #00139785 - Critical Incident (CI) 2900-000005-25 related to falls prevention and management.
- Intake: #00140860 - 2900-000008-25 related to infection prevention and control (IPAC).

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that all recommendations made by the Chief Medical Officer of Health were followed with respect to alcohol based hand rubs (ABHR's) when expired hand ABHR was in use at the home's front entrance.
The ABHR was replaced immediately by home staff.

Sources: Observations of the homes front entrance, interviews with staff.

Date Remedy Implemented: May 13, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care for a resident was based on an assessment. The resident was provided equipment to use prior to completion of a required assessment.

Sources: Progress notes of a resident, interviews with registered staff.

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