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: August 11, 2025
Inspection Number: 2025-1384-0004
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 dates: August 6-8, 11, 2025

The following intake(s) were inspected:
- Intake: #00150594 - Falls Prevention and Management
- Intake: #00151270 - Prevention of 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: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a

risk of harm to the resident.

The licensee has failed to immediately report the improper care of a resident to the Director when improper resident handling resulted in an injury. Afterhours was not called on the day of the incident, a critical incident report was submitted the following day.

Sources: Critical incident report, staff interviews, resident's clinical records.

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)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including pain assessments and reassessments were documented.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for pain management were complied with.

Specifically, the home's pain management program indicated each time a pro re nata (PRN) pain medication is administered, staff are to record pain scores in the Weights and Vitals tab in Point Click Care (PCC) (either numerical or Pain Assessment in Advanced Dementia (PAINAD) Scale) pre-administration and post-administration.

This was not completed when a PRN pain medication was provided to a resident.

Sources: resident's clinical records, the home's pain management program, last revised July 2024, interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring devices and techniques when transferring a resident.

Staff transferred a resident, when they were resisting care, using a device that was not indicated during episodes of resistance. This contributed to resident injury.

Sources: resident's clinical records, interviews with staff.

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) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to ensure the written strategies to prevent or minimize the responsive behaviors of a resident were coordinated and implemented on an interdisciplinary basis.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for managing responsive behaviors were complied with.

Specifically, the home's Personal Expressions Policy indicated residents with personal expressions will have internal reporting protocols implemented. Front line staff failed to report a resident's responsive behaviors to registered staff.

As a result, the registered staff were unable to implement the suggested interventions to manage the resident's responsive behaviors.

Sources: resident’s clinical records, staff interviews, the home’s policy titled “Personal Expressions”, last reviewed July 2024, the home's investigation notes.

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