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
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Original Public Report

Report Issue Date: December 19, 2023	
Inspection Number: 2023-1392-0006	
Inspection Type: Complaint 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 Glen Oaks, Oakville	
Lead Inspector Tracey Delisle (741863)	**Inspector Digital Signature** Tracey DeLisle Digitally signed by Tracey DeLisle Date: 2024.01.12 10:21:13 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 23-24, 27-30, 2023 and December 1, 4-5, 2023.

The following intake(s) were inspected:

- Intake: #00098520 - Regarding the Prevention of Abuse and Neglect Program.
- Intake: #00098773 - Regarding the Prevention of Abuse and Neglect Program.
- Intake: #00099873 - Complaint: Regrading the Prevention of Abuse and Neglect Program.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

Duty of licensee to comply with plan

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Specifically, the plan of care was not followed as it relates to the management of Resident #001 and #002's care needs, procedures and interventions.

Rationale and Summary

A) On a day in September 2023, a scheduled procedure for a resident was not performed in accordance with the Plan of Care.

During the inspection it was confirmed through the clinical records, Long Term Care Home's (LTCH) internal investigation notes and interview with Administration Staff that the plan of care was not followed in accordance with the care plan.

Failure to ensure the Plan of Care was followed put resident at risk for medical implications and subsequently was transferred to hospital due to complications.

Sources: Interview with staff, resident clinical records, internal investigation notes, Internal Policy, and Critical Incident.
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B) On a day in September 2023, it was documented in the clinical records that the resident sustained an injury of unknown origin.

According to the LTCH's internal investigation notes the injury may have been related to the improper technique performed by the staff.

This technique was not an intervention according to the plan of care at the time of the incident. Interview with Administration Staff, confirmed the staff did not follow the plan of care when dealing with the resident.

Failure to follow interventions as outline in the plan of care put the resident at risk of injury due to improper technique.

Sources: Interview with Staff, resident clinical records, LTCH's internal investigation notes, Critical Injury, and Internal Policy.
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