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: January 23, 2025

Inspection Number: 2025-1392-0001

Inspection Type:
Critical Incident
Follow up

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): January 15, 16, 17, 20, 21, 23, 2025

The following intake (s) were inspected:

- Intake: #00126760 – [Critical Incident (CI): 2908-000044-24] – related to Prevention of Abuse and Neglect.
- Intake: #00127844 – [CI: 2908-000048-24] - related to Prevention of Abuse and Neglect.
- Intake: #00128202 – [CI: 2908-000050-24] - related to Prevention of Abuse and Neglect.
- Intake: #00128195 - [CI: 2908-000049-24] - related to Prevention of Abuse and Neglect.
- Intake: #00128907 - Follow-up Compliance Order (CO) #001 from Inspection #2024-1392-0004, FLTCA, 2021 - s. 24 (1), Duty to Protect, CDD: November 15, 2024.
- Intake: #00128908 - Follow-up Compliance Order (CO) #002 from Inspection #2024-1392-0004, FLTCA, 2021 - s. 28 (1) 2, Reporting certain matters to Director, CDD: November 15, 2024.

- Intake: #00130926 – [CI: 2908-000053-24] - related to Prevention of Abuse and Neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1392-0004 related to FLTCA, 2021, s. 24 (1)
Order #002 from Inspection #2024-1392-0004 related to FLTCA, 2021, s. 28 (1) 2.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

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.

A) The licensee has failed to protect a resident from physical abuse by staff of the home.

For the definition of physical abuse, Ontario Regulation 246/22, states that physical

abuse is the use of force by anyone other than the resident that causes physical pain or injury.

An incident of physical abuse towards a resident was substantiated by the home.

Sources: Critical Incident Report, investigation notes, staff disciplinary letters, and staff interviews.

B) The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

O. Reg. 246/22 s.7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified date a resident was found to be neglected by staff of the home.

Sources: A resident's clinical records, the home's internal investigation notes, and staff interviews.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to immediately investigate an allegation of physical abuse against a resident.

An internal investigation was not initiated until four days later.

Sources: Critical Incident Report, investigation notes, and staff interview.

WRITTEN NOTIFICATION: Protection from certain restraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.

The licensee has failed to ensure that a resident was not restrained for the convenience of staff.

On a specified date a resident was restrained preventing the resident from addressing their care needs.

Sources: A resident' clinical records, the home's internal investigation notes, and staff interview.

WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under

subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident and their Substitute Decision Maker (SDM) were immediately notified of the outcome of the home's internal investigation upon completion.

Staff noted that the resident and their SDM were not informed until three days later.

Sources: Critical Incident Report, investigation notes and interview with staff.