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: June 5, 2025
Inspection Number: 2025-1392-0003
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): May 28-30, 2025 and June 2- 5, 2025

The following intake(s) were inspected:

- Intake: #00142894 -CI 2908-000014-25 - related to resident care and support services.
- Intake: #00143631 - Follow-up to CO #001 from inspection # 2025-1392-0002 related to resident care and support services.
- Intake: #00147056 -CI 2908-000017-25 - related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1392-0002 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Medication Management
Falls Prevention and Management

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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed as they endured gait changes.

The resident sustained injuries when they had a fall.

Sources: Interviews with staff, resident's clinical records, Critical Incident (CI) report.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 ensure that the Director was immediately informed of improper care of a resident.

After a staff was notified that a resident had a critical result, the staff discovered a medication was expired and discarded it without informing the management immediately.

Sources: CI report and interviews with staff.

WRITTEN NOTIFICATION: Medication management system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that the written policies and protocols developed for the medication management system to ensure accurate administration were followed.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that the home's medication administration policy was complied with. Specifically,

staff were to use the appropriate code on the Electronic Medication Administration Record (eMAR) when a resident medication was not administered, but instead it was documented as administered.

Sources: Medication Administration Policy last revised June 2024, CNO Practice Standard: Documentation, Revised 2008, resident's clinical records, the home's investigation notes and interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A) The licensee has failed to ensure that a resident's medication was administered in accordance with the directions for use specified by the prescriber when staff failed to administered them.

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

B) The licensee has failed to ensure that a resident's medication was administered in accordance with the directions for use specified by the prescriber when staff failed to follow the prescriber's administration instructions to discard the medication on a specified date after opening and continued to administer the medication.

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

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