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

Central West District
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Public Report

Report Issue Date: April 13, 2026

Inspection Number: 2026-1365-0002

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 West Williams, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 7-10 and 13, 2026

The following intakes were inspected:
-Intake #00170685 - Critical Incident (CI) related to improper care
-Intake #00174309 - Complaint related to falls prevention and management

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

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 (7)
Plan of care
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.

A Personal Support Worker (PSW) did not follow a resident's plan of care related to the level of assistance required for personal care.

Sources: Investigation notes, interviews with staff, and the resident's clinical notes.

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.

When the Director of Care (DOC) became aware of an alleged incident related to improper care, the information upon which it was based was not reported to the Director.

Sources: Investigation notes and interviews with staff.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 3.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
3. The type and level of assistance required relating to activities of daily living.

A resident's care plan did not identify the type and level of assistance required for personal care when they were admitted to the home.

Sources: Resident's care plan and interviews with staff.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (9) (a)
24-hour admission care plan
s. 27 (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change;

A resident was not reassessed by a member of the interdisciplinary team after risks were identified. The plan of care did not outline the risks or changes in care needs until a few days later.

Sources: Resident's care plan, assessments, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning

techniques

NC #005 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.

Staff used unsafe transferring and positioning techniques that resulted in negative impact to a resident.

Sources: CI report and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

A resident sustained a fall which resulted in negative impact. A component of the post-fall assessment was not completed as required.

Sources: Post-fall assessment and interview with staff.