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

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Public Report

Report Issue Date: June 5, 2025
Inspection Number: 2025-1405-0002
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 Willowgrove, Ancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23, 27-29, 2025 and June 2-5, 2025.

The following intake(s) were inspected:

- Intake: #00143369 - was related to falls prevention and management.

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

Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care - Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in their assessment of use of a specified mobility aid device, so that their assessments were integrated, consistent and complemented each other.

On a specified day in May 2025, the resident was observed in the specified device and the progress notes indicated that it was used by the resident on a number of specified dates in May 2025.

A Personal Support Worker (PSW) acknowledged that the resident used the specified device and required a specified transfer method used by staff.

On a specified day in May 2025, an Occupational Therapist's (OT) Referral was sent for the resident's specified device assessment, which was not completed. A Physiotherapist (PT) acknowledged that they were assessing the devices for residents but the OT Referral form was retired and it was not addressed.

Sources: Progress notes, the Occupational Therapist referral; interviews with the PSW and the PT.

WRITTEN NOTIFICATION: Plan of Care - when reassessment, revision is required

NC #002 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.

The licensee has failed to ensure that the plan of care for a resident was reviewed and revised at any other time when their care needs changed in relation to the use of a specified mobility aid device.

The resident's plan of care at the time of inspection did not contain information about using the specified device including directions for transfers. Their progress notes indicated that the device was used on specified dates in May 2025.

A PSW acknowledged that the resident used the specified device for a specified reason and time of the day and the resident required a specified type of transfer method.

On a specified date in May 2025, a Registered Nurse (RN) acknowledged that the specified device was used by the resident starting from a specified day in May 2025, and there were no directions included in the resident's plan of care about the device.

Sources: The resident's plan of care and progress notes; interviews with the PSW and the RN.

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to comply with the pain management program to monitor a resident's responses to and the effectiveness of the pain management strategies in relation to following up on a specified pain medication administered to the resident on a specified day in May 2025.

In accordance with O. Reg 246/22, s. 11 (1) b, the licensee was required to have a pain management program, and that was to be complied with.

Specifically, staff did not comply with the "Pain Management Program" policy in monitoring the effectiveness of a specified pain medication administered to the resident on a specified day in May 2025.

According to the home's "Pain Management Program" policy, staff was required to ensure that the effectiveness of the "Pro Re Nata" (PRN) pain medication was to be evaluated 30 minutes up to 90 minutes after its administration.

On a specified day in May 2025, progress notes indicated that the resident was administered a specified pain medication and a follow up was conducted two hours and 11 minutes after the medication administration, which was acknowledged by a Registered Practical Nurse (RPN). On a specified date in May 2025, the documentation in the Pain Level Summary indicated a specified level of pain assessment conducted for the resident.

Source: Progress Notes, Pain Level Summary, AgeCare Pain Management Program policy; interview with the RPN.