

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: August 11, 2025

Inspection Number: 2025-1405-0003

Inspection Type:

Complaint
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by its 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 dates: July 22-25, 28-31, and August 5 and 7, 2025.

The following Critical Incident intakes were inspected:

- Intake #00147693 was related to falls prevention and management
- Intake #00148977 was related to infection prevention and control

The following Complaint intakes were inspected:

- Intake #00149793 was related to nursing and personal support services
- Intake #00150684 was related to nursing and personal support services
- Intake #00150487 was related to nursing and personal support services
- Intake #00152604 was related to nursing and personal support services and air temperatures
- Intake #00152867 was related to nursing and personal support services and medication management

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

- Medication Management
- Infection Prevention and Control
- Safe and Secure Home
- Staffing, Training and Care Standards
- Reporting and Complaints
- Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for its residents when a maintenance cart was left unattended in a hallway. Tools and chemicals were observed on the cart and within easy reach for residents. The staff member acknowledged that they left the cart unattended while they went to the basement to obtain parts needed to fix a resident's sink. The home's policies on tools and chemicals specified that tools were not to be left unsupervised or where

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they can be accessed by residents, and chemicals were to be kept locked in designated storage rooms/areas to prevent accidental or improper use by staff, visitors or residents.

During follow up observations, the maintenance cart was not left unattended in a resident area.

Sources: observations; Use of Power Tools & Equipment Policy, Chemical Use Policy; and interview with the staff member.

Date Remedy Implemented: July 22, 2025

WRITTEN NOTIFICATION: Nursing and personal support services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 35 (3) (e)

Nursing and personal support services

s. 35 (3) The staffing plan must,

(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the entirety of the written staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

In accordance with O. Reg 246/22, s. 35 (3) (a), the licensee was required to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and Regulation.

Ministry of Long-Term Care

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The annual evaluation of the staffing plan provided by the home did not include any evaluation of the staffing mix and the Executive Director acknowledged that their had been no evaluation they were aware of to confirm that the staffing mix was consistent with residents assessed care and safety needs.

Sources: Observations, the home's staffing plan evaluations, Grievance Form, and interviews with staff and family members.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that any written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

The licensee received several written complaints concerning the care of resident and the operations of the home in June and July 2025 and none of these complaints were forwarded to the Director.

Ministry of Long-Term Care

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Long-Term Care Inspections Branch

Hamilton District

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Sources: Written complaints, and interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC) Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that section 9.1 (b) of the IPAC Standard was implemented when staff did not follow the four moments of hand hygiene prior to donning gloves and/or while portering or assisting residents in the dining room. Section 9.1 (b) specified that the four moments of hand hygiene included before aseptic procedures and before/after resident contact, which four personal support workers (PSWs), failed to do consistently. The IPAC Lead explained that they expected all staff to perform hand hygiene according to the four moments of hand hygiene.

Sources: observations; IPAC Standard for Long-Term Care Homes, Hand Hygiene Program; and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Ministry of Long-Term Care

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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).

The licensee has failed to ensure that on an identified date, a resident was administered a specific drug in accordance with the directions for use specified by the prescriber.

Sources: The resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District

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The licensee has failed to ensure that a medication incident involving a resident was documented with a record of the immediate actions taken to assess and maintain the resident's health.

On an identified date, the resident was found to have not been administered a medication as per the physicians order. As per the Director of Care and the home's medication incident report policy, this incident would have warranted staff to complete a medication incident report and record a full description including actions taken and persons notified in response to the medication incident in the resident's clinical record. No medication incident report was completed nor was anything documented in the residents clinical record relating to this incident.

Sources: The resident's clinical records, the home's medication incidents and adverse drug reactions policy, and interviews with staff.

COMPLIANCE ORDER CO #001 Nursing and personal support services

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 35 (2)

Nursing and personal support services

s. 35 (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the Licensee must:

- 1) Provide education to the staff schedulers and unit clerk on the home's staffing

Ministry of Long-Term Care

Long-Term Care Operations Division
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Hamilton District

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plan, specifically highlighting the regular and minimum staffing mix required per shift. Keep a documented record of the education completed, including what information was reviewed, dates the education was provided and signatures from staff who received the education.

2) Complete an audit of a one week period to ensure that the staffing mix indicated in the staffing plan is being complied with. Keep a documented record of the audit completed, including what dates were included, what the staffing levels were and any remedial actions taken.

Grounds

The licensee has failed to ensure that their written staffing plan was complied with.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that any written staffing plan developed for the organized program of nursing services and organized program of personal support services was complied with. Specifically, the home did not comply with their staffing and contingency plan.

The staffing and contingency plan stated that the minimum PSW staffing levels was four PSWs for day shift, three PSWs for evening shift, and 1 PSW for night shift and that if short the positions would be posted at regular time and that overtime would be awarded. During a one-week period in July 2025, there was one day shift where several neighbourhoods of the home had three PSWs working and five evening shifts where several of the neighbourhoods had two PSWs working. These shifts were posted and several of the available shifts had staff apply for coverage. The staff however were denied due to requiring overtime, no coverage was provided, and the neighbourhoods ran below the contingency plans stated minimum staffing levels.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District

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The Unit Clerk acknowledged they had received communication that the day shift could run with three PSWs and they were unaware of the staffing plans stated minimum staffing levels of four PSWs.

There were several complaints received prior to and during the course of the inspection from staff and family that all alleged that the current staffing levels of both PSWs and registered staff were not providing for adequate care and safety of residents. One resident stated that at times residents were wetting themselves at night and were required to wait for help from staff as there was only one staff member on their neighbourhood and another resident stated that at times they are provided a bed bath opposed to their preferred shower as staff do not have the time. A staff member acknowledged that on one of the low staff dates looked at the home had to provide bed baths to the residents whose bath day it was.

Failing to comply with their staffing plans minimum staffing levels put the residents care and safety at risk.

Sources: the home's staffing plan, staff schedules, the home's staff stat program, and interviews with staff and residents.

This order must be complied with by September 19, 2025

COMPLIANCE ORDER CO #002 Dealing with complaints

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 108 (1)

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to

Ministry of Long-Term Care

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Hamilton District

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the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. The response provided to a person who made a complaint shall include,
 - i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
 - ii. an explanation of,
 - A. what the licensee has done to resolve the complaint, or
 - B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
 - iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

**The inspector is ordering the licensee to comply with a Compliance Order
[FLTCA, 2021, s. 155 (1) (a)]:**

Specifically, the Licensee must:

- 1) Educate the department managers including the Executive Director, Director of

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Long-Term Care Inspections Branch

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Care and Associate Directors of Care regarding O. Reg 246/22 s. 108, specifically ensuring that this includes complaints received from staff if it pertains to the care of a resident or the operation of the home. The education must be provided by a member of the Licensee's head office.

2) Keep a record of what education was provided, including the date it was held, who conducted the education and signatures of those who attended indicating they understood the education.

Grounds

The licensee has failed to ensure that complaints received concerning the care of a resident and the operation of the home were investigated and acknowledged.

There was several complaints made to the management of the home pertaining to safety, provision of care to residents and operational concerns relating to inadequate staffing to meet resident care needs made from staff members of the home and their union representatives. The home was unable to provide any evidence that these complaints were investigated and that any acknowledgement of receipt of the complaint was provided. The home had a complaints policy and procedure in place however the Executive Director informed that this procedure did not pertain to any complaints made from staff members regardless of the nature of the complaint and this is why they had not been investigated or that any documented record was kept.

There was a risk to the residents when the home failed to investigate into complaints pertaining to their safety and care needs.

Sources: Written complaints from staff and Liuna, the home's complaints policy, the

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Hamilton District

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Hamilton, ON, L8P 4Y7

Telephone: (800) 461-7137

home's complaints tracker, and interviews with staff.

This order must be complied with by September 19, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

Ministry of Long-Term Care

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e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.