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: October 20, 2025

Inspection Number: 2025-1405-0004

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 Willowgrove, Ancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 26, 29, October 1-3, and 6-8, 2025.

The following critical incident intakes were inspected:
· Intake #00154221 was related to the prevention of abuse.
· Intake #00155599 was related to the prevention of abuse.
· Intake #00156773 was related to infection prevention and control.
The following follow-up intakes were inspected:
· Intake #00155053 was related to nursing and personal support services.
· Intake #00155054 was related to dealing with complaints.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1405-0003 related to O. Reg. 246/22, s. 35 (2)
Order #002 from Inspection #2025-1405-0003 related to O. Reg. 246/22, s. 108 (1)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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: 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 any standard or protocol issued by the

Director with respect to infection prevention and control (IPAC) was implemented.

The IPAC Standard for Long Term Care Homes section 6.1 states that the licensee shall ensure that there is adequate access to personal protective equipment (PPE) for routine practices and additional precautions. There were two residents on Additional Precautions that did not have the required PPE easily accessible for staff to utilize. On October 1, 2025, the required PPE had been placed at the residents doorways.

Sources: Observations, the IPAC Standard for Long Term Care Homes, and interviews with the IPAC Lead.

Date Remedy Implemented: October 1, 2025

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that an intervention in a resident's plan of care to minimize the risk of altercations and potentially harmful interactions between this resident and co-residents was implemented.

The resident had a specific intervention in their plan of care to minimize risk of altercations. On one occasion, this intervention was not provided as care planned and an altercation between the resident and a co-resident ensued which resulted in an injury to the co-resident.

Sources: The resident's clinical record, and an interview with a staff member.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee has failed to ensure that they complied with their outbreak management system.

The home's outbreak management system for detecting, managing and controlling infectious disease outbreaks instructed staff to notify Public Health when they identified two or more residents of the same neighbourhood as respiratory cases within 48 hours of the original onset. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the outbreak management system were complied with. Specifically, the home's outbreak

management system was not complied with when two respiratory cases in a specific neighbourhood were reported to Public Health two days after being identified.

Sources: The home's outbreak policies, the home's outbreak debriefing notes, and interviews with the IPAC Lead.

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
- Conduct an analysis of the incident of physical abuse which resulted in a significant change in the co-residents health status
- Evaluate the results of the analysis and determine changes or improvements that are required as a result of the analysis.
- Implement the changes or improvements.
- Maintain a written record of the results of the analysis, changes or improvements identified and how they were implemented.

Grounds

The licensee has failed to ensure that two residents were protected from physical

abuse by a specific resident.

Section two of the Ontario Regulation (O. Reg.) 246/22 defined physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

A) On one occasion the specific resident used physical force towards a co-resident which resulted in physical injuries to the co-resident.

Sources: The co-residents clinical records, and the home's investigation notes.

B) On another occasion, the specific resident used physical force towards a different co-resident which resulted in physical injuries, hospitalization, and a significant change in the co-residents health condition.

Sources: The co-residents clinical records, the home's investigation notes, hospital records, and interviews with staff.

This order must be complied with by December 1, 2025

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

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:

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.