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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 4, 2024

Inspection Number: 2024-1373-0004

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 Woodhaven, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 28 - 29, 2024 and December 2 - 4, 2024.

The following intakes were inspected:
An intake for Compliance Order CO #001 from inspection 2024-1373-0003, related to FLTCA, 2021 - s. 3 (1) 11, with a Compliance Due Date (CDD) on November 25, 2024.

An intake for Compliance Order CO #002 from 2024-1373-0003, related to O. Reg. 246/22, s. 40, with a CDD on November 25, 2024.

An intake was related to a fall with injury.

The following intakes were completed in this inspection: three intakes were related with falls with injuries.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1373-0003 related to FLTCA, 2021, s. 3 (1) 11.

Order #002 from Inspection #2024-1373-0003 related to O. Reg. 246/22, s. 40.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee has failed to ensure all doors leading to secure outside areas that preclude exit by a resident, including balconies, must be equipped with locks to restrict unsupervised access to those areas by residents. An observation was made on November 28, 2024, at 1036 hours (hrs) within the Family Room of the Markham Unit where 10 residents were seated inside the room without staff member. The door that led to an outdoor balcony was found to be unlocked.

Sources: Observation, and staff interviews with the Director of Care (DOC).

WRITTEN NOTIFICATION: Pain management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that the resident was assessed using a clinically appropriate assessment instrument when their pain was not relieved by initial interventions. The resident had experienced an event and subsequently experienced pain. An intervention was then administered. Hours later, the pain remained unrelieved, but a comprehensive pain assessment tool was not completed for the resident.

Sources: Resident's electronic health records, and staff interview with the Resident Care Coordinator.

WRITTEN NOTIFICATION: Responsive behaviors

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken, including resident assessment, were documented when the resident exhibited responsive behaviors over a time period. A review of the home's policy suggested a Behavioral Supports Ontario's Dementia Observation System (BSO-DOS) to be completed when residents

exhibited responsive behavior in order to capture behavioral patterns. Such assessment was not completed for the resident and the resident was later sent to a local medical facility for further care and treatment.

Sources: Resident's electronic and physical chart, and staff interview with the BSO Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The licensee has failed to ensure that the Infection Prevention And Control (IPAC) lead designated under this section works regularly in that position on site at the home for at least 26.25 hrs per week.

As per email documentation, the Long Term Care Home's (LTCH) previous IPAC lead resigned on an identified date. The DOC indicated in the interim they were supporting to oversee the IPAC program in conjunction with registered staff from the home. Additionally the Director of Regional Operations (DRO) indicated at the time there was not a formal process in place to ensure there was a designated interim IPAC lead, and to track the amount of the designated IPAC hours. No records were produced related to IPAC lead hours in the home.

Sources: Email records from LTCH, and interviews with the DOC and DRO.