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

Public Report

Report Issue Date: May 14, 2025

Inspection Number: 2025-1373-0003

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 Woodhaven, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 28 to, 30, 2025, May 1, to 9, 12 and 14 2025

The following intake(s) were inspected:

- An intake related to the Infection Control and Prevention Program (IPAC) and an outbreak
- An intake related to an allegation of staff to resident physical abuse
- A complaint related to an allegation of neglect
- A complaint related to resident care and an injury of unknown origin

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 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 failed to ensure that a resident was assessed and had interventions documented after they demonstrated responsive behaviours during an altercation with a co-resident. The resident's Dementia Observation System (DOS) was not completed in it's entirety and had no identified interventions documented in their plan of care. Progress notes, and interviews with staff indicated that another altercation occurred with another co-resident at a later time. Staff also indicated that the information on the DOS was required to create interventions for the resident exhibiting responsive behaviors. The staff also confirmed that the DOS was not completed in it's entirety and that interventions were missing for the resident.

Sources: Clinical records, interviews with staff.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief

Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that an Alcohol-Based Hand Rub (ABHR) with a 70-90% alcohol level was accessible and was not expired when the Inspector observed an expired ABHR. In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024, section 3.1 directs the licensee to ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% ABHR and are not expired.

Sources: Observations, interviews with the IPAC lead.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

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

1) The IPAC lead, and ADOC or designate shall keep a documented record of, and ensure that
a) Registered Nurse (RN) #102, #113, #114, #115 and #116 are trained on the home's policy for outbreak management with regards to the reporting criteria to Public Health.
b) Nursing Unit Clerk (NUC) #109, and any other individuals responsible for the scheduling of staff is trained on the home's policy for outbreak management with regards to cohorting of staff.

2) The IPAC lead, and ADOC or designate shall keep a documented record of, and ensure that a process is developed and implemented to communicate cohorting needs to Nursing Unit Clerk #109 and any other individual responsible for scheduling of staff in the home. The newly developed process should at a minimum include, written communication in response to staff cohorting during suspected and confirmed outbreaks. The IPAC lead and ADOC or designate shall train Nursing Unit Clerk #109 and any other individual responsible for scheduling on this newly developed process.

3) The IPAC lead, and ADOC, or designate shall keep a documented record, and complete a daily audit to determine if staff are cohorted during a suspect or confirmed outbreak. The audit will include the name of the person completing the audit, date/time completed, the names of staff that are not cohorted and Resident Home Area (RHA) worked. If the audit indicates cohorting of staff did not occur, the IPAC lead, ADOC or designate shall provide and document any corrective actions taken.

Documented records should be retained for parts 1 to 3 of the order and made available to inspectors upon request.

Grounds

The licensee failed to ensure that all staff participated in the implementation of the IPAC program, when the Long Term Care Home (LTCH) did not follow its policy on outbreak management.
In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the IPAC program were complied with. Specifically, the home's policy on outbreak management indicated that staff from the affected resident home area (RHA) will remain assigned to that RHA. The staffing schedule was reviewed and indicated that staff were not cohorted.
The policy further indicated that if a resident showed one respiratory symptom they would be isolated, and monitored for progression of further symptoms. Clinical records were reviewed for four residents and indicated missing symptom monitoring on the evening and night shifts. Moreover, there was a delay in placing four residents on droplet contact precautions after they presented with one respiratory symptom. Additionally, the home's policy on outbreak management indicated that Public Health would be notified when two or more residents presented with symptoms within 48 hours. This notification was to occur when identified after business hours including evenings and weekends. Interviews with the Public Health Inspector, the IPAC lead and the Associate Director of Care (ADOC) supporting the IPAC program indicated that Public health should have been informed when two residents exhibited respiratory symptoms on an identified date on one RHA. The ADOC confirmed that Public Health was not notified until two days later. The delays with notifying Public Health, isolating residents immediately, and lack of staff cohorting, and monitoring of residents on every shift impacted how the outbreak was managed and did not minimize the transmission of infection.

Sources: the LTCH's policy titled Outbreak Management, Outbreak Resolution Debrief, York Region Respiratory Outbreak Update Form, clinical records, staffing schedule, and interviews with staff and a Public Health Inspector.

This order must be complied with by June 20, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The IPAC lead, and ADOC or designate shall

1) Ensure that all registered staff working evening and night shifts on the identified Resident Home Areas (RHA's)are trained on the requirements to monitor symptoms on every shift when residents exhibit infectious symptoms and ensure that staff working evening and night shifts on the identified RHA's are trained on the home's policy for outbreak management, specifically with regards to infectious symptom identification, and initiating isolation precaution measures immediately to minimize the transmission of infection. All training records must be documented and include the names and signatures of those who attended the training, dates of the training, contents of the training, and name of the trainers.

2) Complete one audit of a resident exhibiting infectious symptom(s) three times a week on the identified RHA's until the compliance order due date to ensure that

symptoms are monitored and documented on the evening and night shifts. The audit will include the name of the person completing the audit, the RHA, resident name, time of day/shift, and the name of the registered staff on shift. If there is no symptom monitoring documented the IPAC lead, and ADOC or designate will indicate corrective measures taken on the audit.

3) Complete one audit of a resident exhibiting symptoms three times a week on the identified RHA's until the compliance order due date to determine if isolation precautionary measures were initiated immediately. The audit will include the name of the person completing the audit, the RHA, resident name, time of day/shift, and the name of the registered staff on shift. If there is a delay in initiating isolation precautionary measures, the IPAC lead, ADOC or designate will indicate corrective measures taken on the audit.

Documented records should be retained for parts 1 to 3 of the order and made available to inspectors upon request.

Grounds

The licensee failed to ensure that on every shift symptoms indicating the presence of infection in residents were monitored when four residents did not have their symptoms monitored. Clinical records were reviewed for four residents and indicated no documentation of symptom monitoring on evening and/or night shifts on multiple dates.

The licensee also failed to ensure that immediate action was taken to reduce transmission, and isolate residents, when four residents were not immediately placed on droplet contact precautions after they were identified with a respiratory

symptom.

The IPAC lead indicated that the staff required re-education on the number of infectious symptoms required to initiate isolation measures for a resident, and that the staff had thought the residents required two symptoms. The IPAC lead, ADOC and the home's outbreak management policy indicated that resident's exhibiting one infectious symptom must be placed on isolation. The ADOC confirmed that there was a delay in initiating precautions for symptomatic residents and also indicated the need to improve the documentation around symptom monitoring of residents.

The lack of resident monitoring on every shift and the delayed isolation measures impacted how the outbreak was managed and did not minimize the transmission of infection. Additionally, the absence of symptom monitoring potentially affected the communication of the resident's health condition.

Sources: Outbreak Resolution Debrief, York Region Respiratory Outbreak Update Form, clinical records, and interviews with the staff.

This order must be complied with by July 11, 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
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:

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.