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: November 4, 2025

Inspection Number: 2025-1370-0007

Inspection Type:
Complaint
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 Samac, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21-24, 27-31 and November 3-4, 2025.
The following intake(s) were inspected:

- An intake related to the follow-up of a compliance order.
- An intake related to a complainant regarding an allegation of abuse and staffing.
- An intake related to a complainant regarding an injury of a resident.
- An intake related to the injury of a resident.
- An intake related to the fall of a resident.
- An intake related to the breakdown of a major equipment.
- An intake related to an allegation of staff to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1370-0004 related to FLTCA, 2021, s. 24 (1)

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

Continence Care
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Accommodation services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that one of the home's equipment was maintained in a safe and good state of repair, with the cause unknown at the time. Since then, there have been three additional failures. During this inspection, the Inspector observed another malfunction. Staff reported the equipment was down over the weekend and that morning. The home remains unaware of the cause, limiting its ability to implement effective preventive measures.

Sources: Observations and interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to comply with the home's zero tolerance of abuse policy. An allegation of physical abuse involving staff to resident occurred. Staff were made aware

of the incident and the staff members involved in the allegation, continued to provide care to the resident.

Sources: Policies, internal investigation notes, and interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A Critical Incident Report (CIR) was submitted, involving an allegation of staff to resident abuse on a specified date. Staff confirmed that the incident should have been reported to the Director.

Sources: Policies, CIR, a resident's clinical health records, and interviews with staff.

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 3.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
3. Behaviour management.

The licensee failed to ensure that a direct care staff received additional annual training in the management of residents with responsive behaviours.

An allegation of staff to resident physical abuse involving a resident was reported to the

Director. A review of the resident's clinical health records indicated a direct care staff had provided care on a specified date. On review of the education records for the direct care staff, the last date they received training related to responsive behaviours was outside of the annual requirement. During an interview with staff, they indicated staff are expected to complete education pertaining to responsive behaviours annually.

Sources: Education records, interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident’s skin was assessed weekly after an alteration in skin integrity.

Documentation completed by staff on a specified date, revealed a change in a resident's skin integrity. Further review of the resident's clinical health records confirmed staff failed to conduct weekly skin assessments. During an interview staff confirmed that the expectation was that staff are to assess any alterations to a resident’s skin weekly.

Sources: Policies, a resident’s clinical health records, interviews with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 3.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum,

provide for the following:
3. Toileting programs, including protocols for bowel management.

The licensee failed to ensure that a resident had a toileting program specifically for bowel.

Staff indicated that the resident doesn't have a bowel toileting program and required assistance with toileting. Staff confirmed that there was no toileting program for the resident.

Sources: Policies, a resident's clinical health records, and interviews with staff.

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (1)
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. The interdisciplinary team will conduct a review of a resident's current plan of care. The Behaviour Support Ontario (BSO) Lead or designate will develop and implement interventions.
2. Update the resident's plan of care with any changes identified in condition 1. A record of attendees that participated in the review of the resident's plan of care will be provided.
3. The BSO Lead or designate will provide education to staff working on a specified unit,

on the home's internal assessment and monitoring process, for residents expressing responsive behaviours.
4. The BSO Lead or designate will educate staff on a specified unit, on the process of sending referrals to the BSO Lead, when referrals to the BSO Lead are to be completed and who is responsible for completing referrals.

Grounds

The licensee failed to ensure that a resident's responsive behaviour needs were met.

The Director was informed of an allegation of staff to a resident physical abuse. A review of the resident's clinical health records indicated changes to the resident.

Staff confirmed in an interview that portions of the home's internal monitoring process, used to assess the resident, was incomplete. During an interview with staff, they confirmed increased monitoring, and additional interventions could have been implemented to meet the needs of the resident. Staff confirmed that the referral process was not followed and the resident was not referred to the home's internal BSO team for further assessment.

Failing to ensure that the resident's needs were met, placed an increased risk to the management of their responsive behaviours.

Sources: A resident's clinical health records, internal investigation notes, interviews with staff.

This order must be complied with by January 30, 2026.

COMPLIANCE ORDER CO #002 Falls prevention and management

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the

use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Ensure all direct care nursing staff assigned to specific home areas are re-educated on the home's Falls Prevention and Management Program.
2. Staff on the identified home areas are to receive education on the criteria following a resident's fall, and on when to update the resident’s care plan post fall.
3. Develop and implement an auditing process to ensure that residents who are at risk for falls, have their falls prevention interventions implemented by staff.
4. Conduct random audits on different residents who are at risk for falls on specific home areas, to ensure their falls prevention interventions are implemented as per their care plan instructions.
5. Maintain a record of the education and training provided as specified in conditions 1 and 2, including the content, date, signature of attending staff, and the name of the person(s) who provided the education audits, including the dates, who conducted the audits, staff and residents audited, results of audits and actions taken in response to the audit findings.

Grounds

1. The licensee failed to ensure that a fall prevention intervention was provided to a resident specified in their care plan.

A resident had falls on specific dates. Documentation indicated resident was found without an intervention. Staff confirmed that they observed the resident was without an intervention. Staff indicated they were expected to follow the care plan and the resident should have had an intervention in place.

Sources: A resident's clinical health records, policies and interviews with staff.

2. The licensee failed to ensure that the strategies to reduce or mitigate falls for a resident were implemented.

A resident’s care plan included fall prevention interventions. On specific dates, the resident experienced consecutive falls, resulting in an injury. At the time of both incidents, a falls intervention was not in place.

Sources: A resident's clinical health records, policies and interviews with staff.

This order must be complied with by January 30, 2026.

COMPLIANCE ORDER CO #003 Continence care and bowel management

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Educate staff on specific units, on the home's continence care program. A documented record of the registered staff who participated in the training with their name, designation, signature, date and time and the designate who provided the education.
2. Upon receipt of the inspection report, management/delegate will review residents admitted within a specific timeframe to verify completion of the home's clinically appropriate assessment instrument tools designed for evaluating incontinence and implementation of corresponding interventions. Maintain documented records of the completed review including corrective actions if necessary.

Grounds

1. The licensee has failed to ensure that a resident, who is incontinent, received a bowel and bladder assessment using a clinically appropriate instrument on admission.

Sources: Review of a resident's clinical health records and policies.

2. The licensee failed ensure that resident assessments for incontinence included identification of contributing factors, incontinence type and patterns, potential for improvement, and appropriate interventions. Additionally, when required, assessments were not completed using clinically appropriate tools designed for evaluating incontinence.

The home's bowel assessment for a resident was incomplete upon admission and there was no other assessment related to their bowel function. Staff confirmed the expectation is to complete the bowel function assessment upon admission and acknowledged that it was not completed. Moreover, they also acknowledged that the resident didn’t have a toileting program in place.

Sources: A resident’s clinical health records, policies and interview with staff.

This order must be complied with by January 30, 2026.

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.