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: December 17, 2025
Inspection Number: 2025-1370-0008
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 Samac, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 8- 12, 15-17, 2025.

The following intake(s) were inspected:

One intake related to improper care of residents by staff.

One intake related to an outbreak

One intake related to complaint regarding neglect

One intake related to an unexpected death.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dietary services and hydration

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 15 (1) (a)
Dietary services and hydration
s. 15 (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutritional care and dietary services for the home to meet the daily nutrition needs of the residents; and

The resident was not provided with tray service at breakfast and lunch on an identified date, as per the home's nutritional care and dietary services program.

Sources: interview with staff, interview with resident, Resident clinical documentations.

WRITTEN NOTIFICATION: Duty to protect

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

In accordance with Ontario Regulation 246/22, s. 7 defines “neglect” as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The resident was noted to be neglected by staff when staff did not provide care related to assistance with activities of daily living and incontinence care, when the resident had asked for assistance.

Sources: Resident clinical documentations, interview with resident, interview with staff.

WRITTEN NOTIFICATION: Pain Management

NC #003 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.

Resident expressed several episodes of increased pain, which resulted in the resident refusing to participate in recreational activities.

Staff stated they were not aware of a clinically appropriate instrument specifically designed for pain assessment in the home. As a result, other than the numeric pain value documented in the Medication Administration Record (MAR), a pain assessment using a clinically appropriate tool was not completed for the resident, for an identified period of time.

Sources: progress notes, interviews with staff.

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