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

Original Public Report

Report Issue Date: January 31, 2024
Inspection Number: 2024-1392-0001
Inspection Type: Proactive Compliance Inspection
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 Glen Oaks, Oakville

Lead Inspector	**Inspector Digital Signature**
Parminder Ghuman (706988)	Parminder Ghuman Digitally signed by Parminder Ghuman Date: 2024.02.20 12:21:24 -05'00'

Additional Inspector(s) Emmy Hartmann (748)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8-12, 15-16, 18-19 & 22, 2024.

The following intake(s) were inspected:

- Intake: #00105077 - Proactive Compliance Inspection.

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement

Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

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: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
Resident's care plan identified that the resident received their showers twice a week on specified days of the week. The resident identified that they received their showers on different days and not as per care plan.

PSW showed the inspector a Bath Schedule which identified that the resident care plan was inconsistent with practices in the home for bathing schedule .

The care plan was amended to reflect the correct information related to the resident's showers.

Sources: Care plan, Bath Schedule; interviews with resident and PSW.
[748]

Date Remedy Implemented: January 15, 2024

WRITTEN NOTIFICATION: Retraining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Retraining
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that staff were retrained annually in the home's policy to promote zero tolerance of abuse and neglect of residents.
Rationale and Summary
Training records for 2023 identified that 171 of 180 staff were re-trained in 2023.

DOC verified that all staff were not re-trained in the home's policy to promote zero tolerance of abuse and neglect of residents.

There may have been a risk to residents if all staff were not re-trained on the home's policy to promote zero tolerance of abuse and neglect of residents.

Sources: Training Records 2023; interview with DOC.
[748]

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that the interventions and resident's responses on an identified date, were documented.

Rationale and Summary
Resident's care plan identified that they required two staff extensive assistance for dressing, toileting, transferring, and bathing.

A review of the documentation of the care the resident received, identified no documentation for the care that was given on an identified date.

DOC verified that care was provided for the resident on the identified date; but it was not documented.

There was a risk to the continuity of care when interventions and the resident's responses were not documented.

Sources: Care plan, PCC Documentation Survey and interview with DOC.
[748]

WRITTEN NOTIFICATION: Laundry service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (b)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;

The licensee failed to ensure that a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents.

Rationale and Summary
Laundry services program of the home did not have sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents. The PSW's confirmed that supply of face cloth and towels is not sufficient in the home for resident to use. The DOC and Administrator acknowledged that there was not enough supply of face clothes and towels for the resident's to use.

Not sufficient supply of face clothes and towels is affecting resident care.

Sources: Observation of linen cart, interviews with staff, DOC and Administrator.

[706988]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (5)

Infection prevention and control program

s. 102 (5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,

(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;
(f) asepsis;
(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and
(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology. O. Reg. 246/22, s. 102 (5).

The licensee has failed to ensure that the infection prevention and control lead has education and experience in infection prevention and control practices, including, infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; outbreak management; asepsis; microbiology; adult education; Epidemiology and program management.

Rationale and Summary
The home's Infection Prevention and Control (IPAC) lead did not have the education and experience in infection prevention and control practices. During the audio recorded interview with IPAC Lead, they mentioned that they have not completed any formal education for Infection Prevention and Control program but they have spent a day with the Corporate IPAC Lead. IPAC Lead acknowledged that they have not attended any training for being the IPAC lead. They have completed the education in Surge Learning which was for all staff members. They also confirmed that they did not have this education as they were in this role on a temporary basis.

Not having the education and experience in infection prevention and control practices puts the residents at risk for managing infections and keeping the residents safe.

Sources: Surge Learning and Interview with the IPAC lead.
[706988]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 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 lead designated under this section works regularly in that position on site at the home for 26.25 hours per week with a licensed bed capacity of more than 69 beds but less than 200 beds.

Rationale and Summary
The home's current Infection Prevention and Control (IPAC) lead did not work the required 26.25 hours per week as the IPAC lead of the home with a licensed bed capacity of 168 beds. As per IPAC Lead Schedule, they did not comply with the legislative requirement which was acknowledged by Administrator of the home in a recorded interview. IPAC Lead was also the Skin and Wound Care Lead of the Home and they work 2 shifts (15 hours) every week as the Skin and Wound Care Lead. This was confirmed by the home's schedule and in an audio recorded interview with the Administrator of the home that they worked in IPAC role for 22.5 hours and not required 26.25 hours.

Not working in the home for the required number of hours as the IPAC lead puts the residents at risk for managing infections and keeping the residents safe.

Sources: Home's schedule and Interview with the Administrator of the home.
[706988]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs stored in a medication cart were secured and locked.

Rationale and Summary
On an identified date, the medication cart in one of the home area was observed to be unlocked when it was in the hallway, and unattended. Registered staff returned to the medication cart and acknowledged that the medication cart should not have been unlocked when unattended.

DOC verified that they expected drugs stored in the medication cart to be secured and locked.

There was a risk to the security of drugs when the medication cart was not locked when it was unattended.

Sources: Observation; interviews with Registered staff, and DOC.
[748]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.
The licensee has failed to ensure that controlled substances were stored in a separate, locked area within the locked medication cart.

Rationale and Summary
On an identified date, while with Registered staff, the inspector observed controlled substances for administration were stored outside of the locked area within the medication cart in one of the home area. Registered staff acknowledged that controlled drugs should have been in the locked box in the medication cart, and not outside.

The home's Narcotic Policy stated that narcotics in the medication cart were to be kept in a locked storage container in the locked medication cart.

There was a risk to the security of drugs as the controlled drugs were not double locked.

Sources: Observation; Home's Narcotic Policy, last revised December 2017; interview with Registered staff.
[748]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year.

The licensee failed to ensure that their continuous quality improvement (CQI) initiative report contained the written record of the date their resident and family/caregiver experience surveys were taken during the fiscal year.

Rationale and Summary
The home's CQI initiative report did not include the date in which their resident and family/caregiver experience surveys were taken during the fiscal year. The Administrator of the home acknowledged that the survey dates were not written in the report.

Sources: Home's CQI initiative report, website, and interview with the Administrator. 706988]

WRITTEN NOTIFICATION: Copy of the report is provided to the Residents' Council

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the CQI initiative report was provided to the Residents' Council.

Rationale and Summary
On an identified date, the Program Services Manager (PPSM) acknowledged that a copy of the initial CQI initiative report was not provided to the home's Residents' Council for 2023. This was also confirmed by the President of Resident Council.

Sources: Resident Council Meeting minutes and interview with the PPSM and President of Resident Council.
[706988]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents received training on Falls Prevention and Management in 2023.

Rationale and Summary
The home's training records for 2023 identified that not all direct care staff completed the mandatory training as required related to Falls Prevention and Management.

There was a risk that not all direct care staff were familiar with the home's Falls Prevention and Management program when they failed to complete the annual training as required.

Sources: Review of Mandatory completion reports and interview with the DOC.
[706988]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee has failed to ensure that all staff who provided direct care to residents received training on skin and wound care in 2023.

Rationale and Summary
The home's training records for 2023 identified that not all direct care staff completed the mandatory training as required related to skin and wound care.

There was a risk that not all direct care staff were familiar with the home's skin and wound care program when they failed to complete the annual training as required.

Sources: Review of Mandatory completion reports and interview with the DOC.
[706988]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of

pain.

The licensee has failed to ensure that all staff who provided direct care to residents received training on pain management in 2023.

Rationale and Summary
The home's training records for 2023 identified that not all direct care staff completed the mandatory training as required related to pain management, including pain recognition of specific and non-specific signs of pain.

There was a risk that not all direct care staff were familiar with the home's pain management program when they failed to complete the annual training as required.

Sources: Review of Mandatory completion reports and interview with the DOC. [706988]

COMPLIANCE ORDER CO #001 Plan of care

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Ensure that first identified resident's plan of care is followed related to dressing,

toileting, transferring, and bathing.
2) Ensure that second identified resident's plan of care is followed related to dressing and toileting.
3) For a period of three weeks following the service of this report;
a) Complete and maintain a record of weekly audits to ensure that:
i) First identified resident's plan of care related to dressing, toileting, transferring, and bathing is followed.
ii) Second identified resident's plan of care related to dressing, and toileting is followed.
b) Maintain a record of any remedial actions taken if any discrepancies are noted in the audits.

Grounds
The licensee has failed to ensure that the care set out in the plan of care was provided to the first identified resident, as specified in the plan.

Rationale and Summary
First resident's care plan identified that they required two staff extensive assistance for dressing, toileting, transferring, and bathing.

A review of the documentation of the care that the resident received, identified that they were provided one staff extensive assistance, on several days and in different care areas.

PSW identified that after the care was completed to residents, PSWs documented the care they provided in Point Click Care (PCC).

Registered staff verified that the resident's condition fluctuated as the resident had pain in their legs and that they were a two staff extensive assistance for care. They

verified that the resident did not receive the care set out in their plan of care on multiple days in December 2023 and January 2024.

The resident was placed at risk for injury when they were not provided the assistance level they required as per plan of care.

Sources: Care Plan, PCC Documentation Survey report and interviews with PSW and Registered staff.
[748]

The licensee has failed to ensure that the care set out in the plan of care was provided to second identified resident, as specified in the plan.

Rationale and Summary
Second resident's care plan identified that they required two staff total assistance for dressing, and toileting.

A review of the documentation of the care the resident received, identified that they were provided one staff total assistance in December 2023, in the area of dressing and toileting.

PSW identified that after care was completed to residents, PSWs documented the care they provided in PCC. They verified that the resident required two staff total assistance.

DOC acknowledged that the care was not provided as specified in the plan for second identified resident.

The resident was placed at risk for injury when they were not provided the

assistance level they required as per plan of care.

Sources: Care Plan, PCC Documentation Survey report and interviews with PSW and DOC.
[748]
This order must be complied with by March 8, 2024.

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.