Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: December 23, 2024
Inspection Number: 2024-1405-0004
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 Willowgrove, Ancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-6, 10,11, 2024.
The inspection occurred onsite and offsite on the following date(s): December 9, 2024.

The following intake(s) were inspected:

- Intake #00122710/CI #2921-000015-24 related to falls prevention and management.
- Intake #00130418 related to an anonymous complaint regarding resident care and support services.
- Intake #00130562/CI #2921-000023-24 and complaint Intake #00130710 related to prevention of abuse and neglect.

The following intakes were completed :

- Intake #00131963/CI #2921-000025-24 and Intake #00122022/CI #2921-000014-24 related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A. The licensee has failed to ensure that the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary
Resident was scheduled to receive a bath every Tuesday and Saturday morning. Resident appeared clean and well-groomed and stated that they regularly received their bath.

There was no documentation in Point of Care that a bath was completed on several dates from October to December 2024.

The Director of Care (DOC) confirmed that documentation was not completed within Point of Care (POC) by direct care staff as required.

Sources: Resident's care record, interview with DOC and resident, observations.

B. The licensee has failed to ensure that the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary
Resident was scheduled to receive a bath every Monday and Friday morning. They appeared clean and well-groomed.

There was no documentation in Point of Care that a bath was completed on several dates from October to December 2024.

The Director of Care (DOC) confirmed that documentation was not completed within Point of Care (POC) by direct care staff as required.

Sources: Resident's care record, interview with DOC and resident, observations.

C. The licensee has failed to ensure that the provision of the care set out in the plan of care for resident #003 was documented.

Rationale and Summary
Resident's care plan stated that they were scheduled to receive a bath every Sunday and Thursday morning. Resident appeared clean, stated that they preferred a sponge bath and staff assist them when they allow them to.

There was no documentation in Point of Care that a bath was completed on several dates from October to December 2024.

The Director of Care (DOC) confirmed that documentation was not completed within Point of Care (POC) by direct care staff as required.

Sources: Resident's care record, interview with DOC and resident, observations.

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.

The licensee has failed to ensure that resident was protected from abuse by staff.

Rationale and Summary
Ontario Regulation 246/22 s. 2 (1)(a) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain and verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Staff members witnessed on two occasions another staff verbally and physically abusing a resident while providing care to the resident. The resident was visibly upset during both incidents but had no recollection of the events.

Failure to protect the resident from abuse placed them at risk of harm.

Sources: Critical Incident (CI) #2921-000023-24; the home's investigation notes; Interview with the Director of Care (DOC) and others.

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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of resident by staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
Resident was verbally and physically abused by a staff member. The incident was witnessed by two staff members and reported to the staff in charge the same day. However, the staff in charge notified the home's manager a day later and a Critical Incident (CI) report was submitted to the Director the following day.
Throughout the home's investigation and interview with staff, it was found that another abuse incident had occurred earlier involving the same staff toward the same resident. This incident was also witnessed by two staff members who did not immediately report it.

The Director of Care (DOC) admitted that these two incidents were not submitted to the Director as required.

Failing to immediately report two incidents of staff to resident abuse placed the resident at risk of receiving further abuse from the staff.

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Sources: CI #2921-000023-24; the home's investigation notes; interview with DOC and others.