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 7, 2025

Inspection Number: 2025-1370-0002

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): April 28 to 30, and May 1, 2, 5 to 7, 2025

The following intake(s) were inspected:

- One intake related to improper care of resident by staff.
- One intake related to the home's infection prevention and control program.
- One intake related to sexual abuse of resident by a co-resident.
- Two intakes related to neglect of a resident by staff.
- One intake related to laundry services.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights: Right to freedom from abuse

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure a resident was free from abuse when a Personal Support Worker (PSW) verbally abused the resident by telling the resident to defecate in an inacceptable way. The Director of Care (DOC) acknowledged this as a form of abuse which is not tolerated by the home.

Sources: Critical Incident Report, home's Zero Tolerance of Abuse and Neglect Policy and Procedures, Resident's clinical health records, home's investigation notes, and an interview with DOC.

WRITTEN NOTIFICATION: Residents' Bill of Rights: Right to freedom from neglect

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 5.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee has failed to ensure that a resident was not neglected. The Director of Care (DOC), and a Personal Support Worker (PSW) confirmed safety rounds were not conducted on a resident during a specific shift. The resident was not transferred into bed and did not receive care as per the plan of care. The resident was found in their wheelchair, in an undignified manner on a specified shift by another PSW. The DOC acknowledged this as neglect.

Sources: Critical Incident Report, Home's zero tolerance of abuse policy, Resident's clinical health records, Home's investigation notes, Interviews with DOC and PSW.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure the staff who provided direct care were kept aware of the contents of a resident's plan of care. The home's investigation notes and the Director of Care (DOC), in an interview, confirmed that two Personal Support Workers (PSW) did not read the resident's care plan and thus did not offer toileting to the resident.

Sources: Home's investigation notes, the resident 's clinical health records, and an interview with DOC.

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) (a) (i)
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,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,

The licensee has failed to ensure resident's linens are changed when needed, as a resident's bed linens were not changed when soiled on a specified date.

Sources: Home's investigation notes which included photo of dirty pillowcase, and an interview with staff.

WRITTEN NOTIFICATION: Retraining

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (1)
Retraining
s. 260 (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The licensee has failed to ensure that all staff who provided direct care to residents completed annual retraining on the Resident's Bill of Rights. Surge records from 2024 indicated that five direct care staff did not complete training in Resident Bill of Rights, including zero tolerance of abuse and neglect.

Sources: Surge Learning Education 2024 records and interview with staff.

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