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: June 10, 2025
Inspection Number: 2025-1370-0003
Inspection Type: 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): June 4, 5, 9, 10, 2025

The following intake(s) were inspected:

- A intake related to the neglect of a resident by staff.

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

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

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

Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a Personal support Worker (PSW) used safe positioning techniques when they assisted a resident.

A Critical Incident Report was reported to the Director related to the fall of resident while the PSW was repositioning the resident.

The PSW repositioned the resident alone.

The resident's care plan required two staff were needed to for repositioning.

Sources: CIR, Resident's electronic medical records, Long Term Care Homes internal investigation notes and interviews with a PSW and Director of Care.

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