

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

Public Report

Report Issue Date: January 29, 2025
Inspection Number: 2025-1384-0001
Inspection Type: Complaint Critical Incident
Licensee: Regency LTC Operating Limited Partnership, by its general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.
Long Term Care Home and City: AgeCare Brant, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 21, 23, 24, 27, 28, and 29, 2025.

The following intakes were inspected:

- Intake: #00126174 for a Critical Incident (CI) report related to duty to protect and falls prevention and management.
- Intake: #00128035 for a CI report related to resident care and plan of care.
- Intake: #00132352 for a complaint related to duty to protect, falls prevention and management, maintenance services and communication and response system.
- Intake: #00135589 for a CI report related to a duty to protect.

The following intakes were completed this inspection:

- Intake: #00127237 related to a CI report related to falls prevention and management.
- Intake: #00129055 related to a CI report related to falls prevention and management.

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

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

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Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

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

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:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with courtesy and respect when staff made an inappropriate comment.

Sources: A resident's clinical records, investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided

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to the resident as specified in the plan.

The licensee has failed to ensure that a resident was positioned as specified in their plan of care.

Sources: A resident's clinical records, investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

Accommodation services

s. 19 (2) Every licensee of a long-term care home shall ensure that,

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home, specifically a baseboard, doors and ceiling tiles were maintained in a good state of repair.

Sources: Observations of the home and interviews with staff.

WRITTEN NOTIFICATION: Screening measures

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 81 (1)

Screening measures

s. 81 (1) Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers.

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The license has failed to ensure that screening measures were conducted in accordance with the regulations before they hired a staff member.

O. Reg 246/22 s. 252 (1) applies where a police record check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 81 (2) of the Act.

A staff was hired in 2023; however, the employee file did not include a vulnerable sector check.

Sources: An employee file and interview with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #005 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 has failed to ensure that staff used safe transferring and positioning techniques when they assisted a resident independently.

Sources: A resident's clinical records, investigation notes, and interview with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

Dealing with complaints

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s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(e) every date on which any response was provided to the complainant and a description of the response.

The licensee has failed to ensure that the documented record of four complaints received, in 2024, included the dates that responses were provided to the complainant or a description of the responses provided.

Sources: Review of Complaints Log and Investigation Templates and interview with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (3) (a)

Dealing with complaints

s. 108 (3) The licensee shall ensure that,

(a) the documented record is reviewed and analyzed for trends at least quarterly.

The licensee has failed to ensure that all complaints received in 2024, were documented on the Complaints Log or included in the quarterly review or analyzed for trends.

Sources: A review of progress notes for a resident, review of portions of 2024 Complaints Log, review of Quarter three and four of 2024 Complaints Analysis and interview with staff.