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

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Public Report

Report Issue Date: October 16, 2025
Inspection Number: 2025-1384-0006
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 Brant, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7-10 & 14 &16, 2025.

The following intake(s) were inspected:
-Intake: #00157401 - related to resident care and support services.
-Intake: #00157545 - related to prevention of abuse and neglect.
-Intake: #00157863 - related to prevention of abuse and neglect.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 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 protect a resident from neglect and physical and emotional abuse by a Personal Support Worker (PSW).

Section 7 of Ontario Regulation (O. Reg.) 246/22 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines "physical abuse" as the the use of physical force by anyone other than a resident that causes physical injury or pain.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines "emotional abuse" as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A PSW failed to complete required rounds, failing to provide required resident care. The following day, while providing care to a resident, the PSW was rude and rough

with the resident's care, causing an injury and emotional distress. The resident stated that the impact was severe and they still feel apprehensive when care is provided.

Sources: Critical incident, review of resident clinical records, resident and staff interviews.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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 devices and techniques when assisting a resident.

Staff transferred a resident using a lift with a remote control that was not functioning correctly. The Director of Care (DOC) acknowledged that the remote control issue caused an unsafe transfer that resulted in a resident's injury.

Sources: resident's clinical health records; resident and DOC interview; policy, Resident Lift and Transfer Program, last revised July 2024.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that, for a resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

During an Inspection related to a critical incident, a record review revealed that a resident, who had a history of demonstrated responsive behaviours, did not have strategies developed and implemented to respond to these behaviours, where possible.

Sources: Resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that, for a resident, steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

A resident altercation caused a resident to fall sustain an injury. A record review revealed that a resident, who had a history of demonstrated responsive behaviours, did not have assessments completed or interventions documented to respond to their needs.

Sources: Critical incident, resident's clinical records, staff interviews, Reactive Expressions Policy, Revision Approval Date: January 2025.

WRITTEN NOTIFICATION: Maintenance services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that procedures were implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

The home's Safe Lifts and Transfers policy directed staff to complete an inspection checklist at the start of every shift and lifts found with deficiencies would not be

used until corrective action/maintenance was taken.

Deficiencies with the lift remote were documented on several dates. The DOC acknowledged that the lift was being used to transfer a resident, after deficiencies were documented and the Environmental Services Manager (ESM) confirmed that they were not notified of the deficiencies with the lift remote.

Sources: Daily Portable Ceiling Lift Inspection Checklist; interviews with resident DOC, ESM.