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

Hamilton District
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Public Report

Report Issue Date: July 18, 2025
Inspection Number: 2025-1318-0003
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 Wenleigh, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): July 14, 15, 16, 17, 18, 2025

The following intake (s) were inspected:
-Intake: #00150001 - [Complaint] related to Pain Management and Skin and Wound Prevention and Management.
-Intake: #00152143 - [Critical Incident (CI): 2833-000015-25] related to Prevention of Abuse and Neglect.

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

Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Pain Management

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.

Section 2 of Ontario Regulation 246/22 defines 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".

The licensee has failed to protect a resident from verbal abuse by a visitor of the home when they were spoken to in a verbally inappropriate manner.

Sources: Critical Incident Report, the home's internal investigation notes, and a resident's progress notes.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 the Director was immediately notified when staff of the home had reasonable grounds to suspect verbal abuse against a resident.

Sources: Critical Incident Report, a resident's progress notes, and the home's abuse and neglect policy.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition

intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that an assessment was completed by a dietician when a resident altered area of skin condition worsen. Hydration and nutrition assessment was not conducted.

Sources: A resident's progress notes, the home's skin and wound care policy, and staff interview.