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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: December 9, 2025

Inspection Number: 2025-1365-0005

Inspection Type:
Critical Incident
Follow up

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 West Williams, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 26-27, December 1-5 and 9, 2025
The inspection occurred offsite on the following date(s): November 27, 2025

The following intake(s) were inspected:
-Intake: #00158695 - CO Follow-up #: 1 - FLTCA, 2021 - s. 24 (1)
-Intake: #00158731: Related to Infection Prevention and Control.
-Intake: #00160356 and Intake: #00160690: Related to Resident Care and Services.
-Intake: #00162441: Related to Fall Prevention and Management.
-Intake: #00163154: Related to Prevention of Abuse and Neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1365-0004 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A.) A staff member received a complaint from a resident's family member which involved concerns about a staff member who provided rough and improper care to the resident. This incident was not reported to the Director until three days later.

Sources: Critical incident report, Interviews with staff.

B.) The licensee did not immediately report a suspicion of improper or incompetent treatment or care related to a resident after staff had provided care to the resident and the resident sustained an injury.

Sources: Critical incident report, A resident's progress notes, Interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The required skin assessments were not completed when a resident returned to the home from the hospital.

Source: Skin and Wound Care Program Policy, clinical records, and staff interviews.

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A staff member was observed exiting a resident's room and did not perform hand hygiene as required.

Sources: Inspector observation, Interviews with staff.

WRITTEN NOTIFICATION: CMOH and MOH

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

On one day during a confirmed outbreak, high-touch surfaces were cleaned and disinfected only once instead of the required twice per day.

Sources: Cleaning checklists, Interviews with staff.